7500 SW 61st Ave #500, Ocala, FL 34476
Phone: (352) 854-0968

CERTIFICATION AND AUTHORIZATION

Patient Name : _____ Date: ____/_____/_____

1 AUTHORIZATION FOR TREATMENT
I hereby certify that I can read, speak and understand the English language and hereby consent to and authorize the doctor to perform any tests or treatments that in his judgment are considered necessary and advisable for the detection, diagnosis and treatment of oral diseases. Also, I authorize the doctor to administer local anesthetics and other medically indicated drugs and to use dental materials he deems necessary for such operative and technical procedures necessary to complete a diagnosis and/or recommended treatment.

Patient's Signature _____

2 CONSENT TO BE PHOTOGRAPHED
I authorize the doctor and staff to take and record, photographs, movies, and audio or videotapes of me for records, teaching, research and publication purposes. It is specifically understood that in any publication or use I shall not be identified by name, and the photographs, movies, and audio or videotapes of me may be modified or retouched in any way that my dentist in his discretion may consider desirable. I further understand that any publication of any photograph in any form which depicts my likeness and or is recognized to be me shall be done only with my expressed written permission.

Patient's Signature _____

3 RELEASE OF INFORMATION
I hereby authorize the doctor to release information to my insurance company for my treatment and care and, if requested, to my referring physician or any healthcare facility responsible for my care. This includes: authorization to release information pertaining to attention and treatment for this period of illness, and other information as may be required to secure payments for charges incurred by me or in my behalf including a diagnosis of my condition.

Patient's Signature _____

4 GUARANTOR AGREEMENT
I hereby agree to pay all charges connected with this treatment.

Guarantor's signature _____

PATIENT'S ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

I, _____, may receive upon request, a copy of the Notice of Privacy Practices of the office of Alex Hoyos DDS. MS, PA

Please opt out:

[ ] I do not want appointment reminder messages left on my home answering system.

[ ] I do not want appointment reminder messages left on my business answering system

[ ] I do not want my protected health care information to be released to the following person:

[ ] I do not want my protected health care information to be released to the following person:

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Print name _____ Patient's Signature _____