ASSOCIATED DENTISTS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices. (Please Print)

_____ _____
Signature Date

FINANCIAL DISCLOSURE AND CONSENT AGREEMENT

I authorize the Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize consent that the Doctor may choose and employ such assistance as he deems fit. I understand the use of anesthetic agents embodies a certain risk.

I agree to be responsible for payment of all services rendered on my behalf or on my dependent's behalf. I understand that payment is due at the time of service unless other arrangements have been made. I understand that all charges 60+ days overdue may be assessed a .75% monthly finance charge (8% APR). I further understand that I am responsible to pay reasonable attorney's fees and costs of collection in the event of default. I authorize Associated Dentists to obtain a credit report if necessary.

_____ _____
Signature Date

If, on behalf of the patient, a personal representative signs this consent, please complete the following:

_____ _____
Personal Representative's Name Relationship to Patient

AUTHORIZATION FOR SUBMISSION OF CLAIMS, ASSIGNMENT OF BENEFITS AND RELEASE OF HEALTH INFORMATION

I request that payment of authorized insurance benefits be made to Associated Dentists, LTD. for any services provided to me by any provider employed or contracted by this clinic.

I authorize any holder of medical/dental information about me to release for hospital or health care service plans, insurance companies, self-insurers or their representatives, any and all information and records (including x-rays) about my dental history and/or services rendered or treatment provided to me. I understand that this information will be used to review, investigate or evaluate any claim for benefits. This assignment will remain in effect until revoked by me, **in writing**. A photocopy of this assignment is to be considered as valid as the original.

I am responsible for any balance not covered by my insurance.

_____ _____
Signature Date

If, on behalf of the patient, a personal representative signs this consent, please complete the following:

_____ _____
Personal Representative's Name Relationship to Patient