CONSENT/AUTHORIZATION/ACKNOWLEDGEMENT

CLINICAL

1 . I authorize Carothers Parkway General Dentistry, referred to as "practice" hereafter, to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis.

2. I authorize the practice to perform all recommended treatment and agreed upon treatment. I also authorize the use of anesthetics, sedatives and other medication (as needed) an am fully aware that using anesthetic agents involves certain risks.

FINANCIAL

3. I am responsible for payment for all services rendered on my behalf and my dependents. I have been informed that payment is due when services are rendered. I am aware that 1.5% MPR or 18% APR is automatically tabulated into my account if my balance is 30 days or older. Should my account become delinquent, I will assume all additional collection costs and legal fees.

4. A $50 Broken Appointment fee will be charged to my account for all broken and/or last minute cancellation. I am aware that to hold down operating costs, 24-hours notice if cancellation is required.

INSURANCE

5. I authorize this practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representative, any and all information, records and radiographs about my medical history, services rendered and treatment necessary.

6. I authorize this practice to submit claims for payment for services rendered or pre-authorizations necessary to mu insurance company, on my behalf and in my name as "signature on file" and assign to this practice the insurance benefits providing assignment is accepted. I understand that I am responsible for payment regardless of the coverage provided.

7. I understand that I am responsible for the deductible, co-payment and excess over the maximum on the day of services.

HIPAA: Acknowledgement of Receipt of Notice of Privacy Practices

8. I have received a copy of this practice's Notice of Privacy Practices

HIPAA: Consent for Use and Disclosure of Health Information

Notice of privacy practices: You have a right to read this practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. Please read this notice prior to signing this consent. This practice reserves the right to change policy practices as described in our Notice of Privacy Practices. If changes are made, a revised Notice of Privacy Practices containing the modifications will be issued. These changes may apply to any of you protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting: Kendra Lawyer- (615) 771-7123. You have the right to revoke this Consent for use and Disclosure of Health Information at any time by giving us written notice of you revocation submitted t the contact person listed above. This revoke will not affect previous consent. We reserve the right to provide further treatment in your behalf or that of your dependents if this Consent is revoked.

9. I have had opportunity to review and obtain a copy of this practice's Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, to use and disclose my protected health information to carry out treatment payment activities and health care operation.

Signatures below indicate that I have read this entire document and fully understand the contents of this Consent/Authorization/Acknowledgement. I have been provided with the opportunity to ask questions ad obtain further clarification.

____________________________ ________________________

Signature Date

Circle one: Adult patient Guardian Personal Representative

If signature provided represents the patient's guardian or "personal representative" please complete the Following

______________________________ __________________________

Patients name DOB or Patients signature DOB