NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1 Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2 Obtain payment from third-party payers
3 Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____.

Relationship to Patient: _____.

Signature: _____.

Date _____.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason:

A NOTE TO OUR PATIENTS

Regarding Your Dental Insurance:

Dental insurance is a wonderful benefit that your employer has chosen to provide for you. Your specific dental plan is one chosen from literally hundreds of combinations available. Some plans may cover as little as 0% or as much as 100% of specific dental services. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage of the reimbursement level than that indicated on your dental plan.

We do not believe that it is in the patient's best interest to compromise the doctor's recommended treatment in order to accommodate an insurance program's maximum benefits that may be considerably less than optimal. We have found that insurance companies may alter their benefits without informing us of these changes. Therefore, we cannot guarantee an insurance company's consistency in your individual plan's coverage.

As a courtesy to you, we will be happy to bill your insurance company and work with you to maximize your benefits. Even though we are able to give you an estimate of costs and benefit coverage, it is not our responsibility to know what the final insurance payment will be. Your final financial obligation can not be determined until all insurance payments are received. ALL unpaid portions are the responsibility of the patient. Any portion not paid 90 days from the treatment appointment will be considered past due and will incur a 1.5% finance charge per month which is 18% per annum. Please remember that the financial obligation for your treatment is between you and this office. No question is too small for you to ask, whether it is about your treatment, benefit plan or statement. We are here to help you.

Regarding Our Office Policies:

Please notify us at least 24 hours in advance if you are unable to keep your appointment. A charge of thirty dollars ($30.00) per hour of reserved time may be applied to broken or missed appointments without notice and will NOT be covered by your insurance. In addition, should your account be transferred to a third party for collection, you will be responsible for a one hundred dollar ($100.00) collection fee. IN THE EVENT A COUPON WAS USED FOR YOUR INITIAL VISIT, PLEASE BE ADVISED THAT ANY X-RAYS TAKEN WERE PROVIDED AT NO COST TO YOU, AND THEREFORE IF YOU CHOOSE TO HAVE YOUR RECORDS FORWARDED IN THE FUTURE, YOU WILL BE RESPONSIBLE FOR 100% OF THE APPLICABLE FEE OF THE X-RAYS.

My signature indicates that I have read and understand the above information.

Responsible Party signature:_____ Date: _____