Financial Policy and Release Benefits

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Feel free to ask about our fees, Financial Policy, or your responsibility.

IF YOU HAVE INSURANCE

Dental insurance is a contract between you and your insurance company. It is your responsibility to understand the extent and limits of your coverage, and to provide our staff with accurate information to process your claim efficiently (i.e. insurance company address, phone number, etc.). It is not our place to enter into disputes between you and your insurance company regarding deductibles, copayments, etc. other than to provide factual information. We do not directly participate with most Insurance programs; however, as a courtesy, we do process your claim for payment to be made directly to you. Certain conditions may apply to your financial arrangements that may require your authorization for release and assignment of benefits. Your signature below authorizes us to offer this when it applies to your situation. If we do not participate with your insurance, 100% of the total cost is requested at the time of treatment. If you are unable to pay 100%, affordable payment options are available. Our staff will help you process whatever paperwork is required. However, the ultimate responsibility lies with you for payment of any and all monies due.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT

RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize this office to release to your benefit program or its representative any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize, if applicable, payment to be sent to this office.

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

Patient Name:_____

Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIPPA CONSENT FORM

****You May Refuse to Sign This Acknowledgement****

By request, I, _____, have received a copy of this office's Notice of Privacy Practices.

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Date:_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information as described in our notice of privacy practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, 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. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT BY REQUEST.

Include completed Consent in the patient’s chart.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACFESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (HEREOUT REFERRED TO AS PHI)

We use and disclose health information about you for treatment, payment, and healthcare operations. The following are examples of uses and discloses of your information that may be made by our office. These examples are not meant to be exhaustive, but to describe types of uses and disclosures.

Treatment: Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the dental practice.

We will use and disclose your PHI to manage your dental care and any related services. This may include the coordination of your health care with a third party. We will also disclose PHI to other dentists who may be treating you such as a specialist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you and receive payment. We may also disclose your PHI to another dentist or health care provider (specialist, laboratory, study club) who, at the request of your

dentist, becomes involved in your care by providing assistance with your diagnosis or treatment or research support.

Payment: We may use and disclose your PHI to obtain payment for services we provided to you. This may include PHI to satisfy requests from insurance plans determining eligibility or coverage for benefits and reviewing services provided to you for medical necessity and undertaking utilization review activities. We may also disclose PHI through billing statements that are sent to your home under the name and address we have on file as primary guarantor of account.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities and technology maintenance.

We may use or disclose your PHI to discuss topics related to treatment (for example: evaluation of study models, radiographs, laboratory results or oral hygiene practices) with patients and /or parents in open treatment areas, X-ray, and reception areas. Your name may be visible on a schedule posted in treatment areas and your name may be disclosed when greeting you or inviting you into a treatment area.

We may use or disclose your PHI to provide you with appointment reminders (such as voicemail messages, postcards, or letters and informational newsletters.) Others who have access to your voice mailboxes may hear these messages. Also, calls being made from our office may be overheard by others in the area. Messages of appointments may also be left with others at a contact number that you provide for us.

To Your Family and Friends: We must disclose your health information to you. We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payments for your healthcare, but only if you agree that we may do so.

Persons involved in your care: We may use or disclose PHI to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure your PHI, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our

professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of PHI of inmate or patient under certain circumstances.

Your Authorization: In addition to our use of you PHI for treatment, payment or healthcare operations, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you a reasonable fee for each page and for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request

this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing. And it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human services upon request.

REVOCATION OF CONSENT

I,_____, revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Print Name:_____

Signature:_____

Date:_____

Informed Consent

Potential Risks and Limitations Of Dental Treatment

As a rule, excellent dental results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering dental treatment in our office recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contra-indicate treatment but should be considered in making the decision to submit to dental treatment.

Perfection is our goal. However, in dealing with human beings, and problems of growth and development, the ravages of dental disease, genetics and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted. We will do everything within our capacity to insure the best possible care.

Throughout life teeth are constantly changing. Periodic examinations should be made so any disease can be treated promptly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and plaque removal is a must.

On rare occasions the nerve of a tooth may die and become infected. A tooth that has been damaged by deep decay, a minor blow or extensive dental treatment can die over a long period of time. An undetected non-vital tooth may flare up during any dental treatment, and may require endodontics (root canal) treatment to maintain it. It may even have to be removed. There is also a risk that during or following treatment soreness or tenderness may occur in the temporomandibular joints (lower jaw joints).

The total time for treatment can be delayed beyond our estimate. Treatment plans can change due to altered conditions which may surface during treatment. Decay which may appear small on x-ray, may be larger than anticipated resulting in much more extensive treatment.

Informed Consent

I understand that during treatment occasionally any of the above problems may occur. These can include but are not necessarily limited to: pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high speed dental equipment.

I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that for a successful result and to lessen the dangers of complication, the following conditions are essential on my part:

1.Excellent oral hygiene

2.Proper diet controls

3.Strict adherence to instructions

4.Cooperation in keeping appointments

I understand that there is no warranty or guarantee to my result and/or care, I also understand that I can, at any time, ask for and receive a full recital of all possible risk related to my treatment.

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification: who are constantly late for their appointments: who continue to excessively cancel their appointments: who fail to practice acceptable oral hygiene: or who are uncooperative with staff providing care.

Print Name:_____

Signature:_____

Date:_____

Media Consent and Release Form

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to High Plains Periodontics and Implant Dentistry and its affiliates and agents to use my image and likeness and/or any interview statements from me in its publications, advertising or other media activities (including the Internet). This consent includes, but is not limited to:

(a) Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/or record my voice;

(b) Permission to use my name and tapes;

(c) Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness.

(d) Permission to use pre-operative and post-operative photos in educational or marketing presentations as the doctor does several educational courses for the dentists in the area. We will maintain anonymity with your photos. If we have any identifying photographs, we will call to ask for verbal permission prior to using such photos.

This consent is given in perpetuity, and does not require prior approval by me

Print Name:_____

Signature:_____

Date:_____

The below signed parent or legal guardian of the above-named minor and/or child hereby consents to and gives permission to the above on behalf of such minor child.

Signature:_____

I certify that I have read this consent form in full to the parent/legal guardian whose signature appears above.

Signature of Practice Representative: _____