FOREST SQUARE

Dental

Notice of Privacy Practices Acknowledgement

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- 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 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 Privacy 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 than you are bound to abide by such restrictions.

Signature: _____ Date: _____

Authority Granted to Treat

I hereby grant the authority for Scott C. Roberts, DDS or Nicholas Jones, DDS to administer such treatment and anesthetics as may be deemed necessary in the diagnosis and treatment of my case. I acknowledge that I have been informed of the risk of the procedure proposed and do authorize Dr. Roberts and/or Dr. Jones to proceed. Possible risks are paresthesia, numbness, excessive bleeding, allergy to medications, improper healing, dry sockets, damage to adjacent teeth, jaw fracture and sinus exposure leading to fistula.

Signature: _____ Date: _____

Disclosure Acknowledgement

I understand and agree that, regardless of my insurance coverage, I am ultimately responsible for the balance of my account for any professional services rendered and that payment is to be made in full at the time of my appointment. I understand that the insurance estimate provided to me is not a guarantee that my insurance will pay exactly as estimated. I authorize my insurance company to pay my dental benefits directly to my dentist office. I have read all the information on this paperwork and I certify that the information I provided is true and correct to the best of my knowledge. I understand that providing incorrect information on my medical history can be dangerous to my health. I will notify you of any changes in my status or in the above information. This information will be kept confidential. I am responsible for updating this information if and when there are changes.

Signature: _____ Date: _____

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