CONSENT TO DENTAL TREATMENT

I HEREBY CONSENT AND AUTHORIZE Uptown Family Dentistry, its associates and employees, to the rendering of dental care, which may include routine diagnostic procedures and such dental treatment as my dentist considers necessary. I also understand it is customary, absent emergency or extraordinary circumstances, that not substantial procedures will be performed upon me unless or until I have had an opportunity to discuss them with a dentist or other health care professional to my satisfaction. If I am a competent adult, I have the right to consent or refuse to consent. I understand that the practice of dentistry and surgery is not an exact science and that diagnosis and treatment may involve risk of injury or even death and acknowledge that no guarantee has been made to me as the results of any examination or treatment in this office.

Initials_____

RELEASE OF DENTAL INFORMATION

I authorize Uptown Family Dentistry to release to requesting Dental Insurance carrier(s), their representatives and auditors, and any referring dental care providers, such as diagnostic and other health care information(including any information relating to treatment for alcohol and substance abuse and/ or confidential HIV and Hepatitis related information, as may be necessary for them to determine benefit entitlement; to process payment claims for dental care services provided during this visit, for continuing care/treatment. A photocopy of this authorization shall be considered as effective and valid as the original. The undersigned also authorizes Medicare, when applicable, to release to another insurance carrier, upon their request, medical information needed to make payment to make payment upon that claim.

Initials _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Notice of Privacy Practices. The Notice describes how my dental health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be change at any time. I may obtain a revised copy of the Notice by contacting this Organization's offices or on this Organization's website at www.hsh.org

Initials_____

INSURANCE ASSIGMENT OF BENEFITS

I AUTHORIZE PAYMENT DIRECTLY TO Uptown Family Dentistry of all benefits payable under my insurance policies. I understand I am responsible to the Dentist of Uptown Family Dentistry for all charges not covered by this assignment.

Initials_____

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDERS, DENTIST AND PATIENT

I request payment of Authorized Medicare benefits to me or on my behalf for any services furnished me by or at Uptown Family Dentistry including dental services. I authorize any holder of dental and other information about me, to release to Medicare and its agencies any information needed to determine these benefits for related services.

Initials_____

MEDICAL ASSISTANCE RECIPIENT

My signatures certifies that I received a service from Uptown Family Dentistry and Dr. _____on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State Laws. I understand that certain tests and procedures may not be reimbursed by Federal and State funds and that I may be responsible for non-covered charges. Also, I agree that if at the time of service, if I am not eligible for Dental Assistance. I will be responsible for balances owed to Uptown Family Dentistry.

Initials_____

I have read and understand each of the sections contained above. I understand that by signing this document, I am agreeing and providing the authorization/consent contained in each of the above sections where my initials are located. I have had the opportunity to ask questions regarding each of these sections and all such questions asked have been answered to my satisfaction.

Signature_____ Witness_____

Relationship to Patient_____ Date_____