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Welcome to our practice! This document contains the information required by law and many Health Plans to protect your rights, inform you of your rights and responsibilities. We are sorry that it is of such length, but we must comply with the terms and conditions that are imposed upon us so that we may serve you. By signing this form you are granting consent, authorizing and agreeing to the following terms and conditions:

Our Notice of Privacy Practices: I acknowledge receipt of Privacy Practices, which provides more detailed information about how Dental One LLC may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this clause, and we encourage you to read it in full. You may obtain a copy of the current and revised notice by contacting our office. You may also take a written copy of the notice with you. You do not need to acknowledge receipt of our notice in order to receive care. Initials: _____Date: ____/____/_____

All Other Insurance Companies and/or Third Party Payers: I HEREBY AUTHORIZE Dental One LLC and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Dental One LLC rendering the service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Guarantee of Payment: I UNDERSTAND that filing a claim with my insurance company or other third party payer, under any circumstance, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Dental One LLC to me or the patient as indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. But is not limited to, claims filed for Workers' Compensation and/or other claims due to personal injury accidents/illnesses, which physicians, suppliers, and practitioners will bill and collect separately for their services. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment either because the plan deems such services not medically necessary or for any other reason.

Consent to Treat: I, as the legal guardian and legal representative of the minor named below, authorize and request Dental One LLC, to provide medical care to the child or minor reasonable by today's standards at Dental One LLC.

I hereby AUTHORIZE examination and dental treatment for the diseases for which I have consulted this practice.

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

PATIENT SIGNATURE DATE

_____ _____

(if patient is 18 years or older, his/her signature is required in addition to the "responsible party")

RESONSIBLE PARTY (if other than the patient) DATE

_____ _____