CONSENT FOR SERVICES, USE AND DISCLOSURE OF HEALTH INFORMATION

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 to carry out treatment, payment activities, and healthcare operations.

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: Contact Person: Kat Davis Telephone: (334) 271-6333 Fax: (334) 271-8875 Address: 4736 Berry Blvd., Montgomery, AL 36106 E-mail: info@stevedavisdmd.com

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.

SIGNATURE

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 heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Payment IS due at the time of service. Payments can be made with cash, check or credit card. Extended payment plans may be available.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment for all dental services provided. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our fees will be paid by an insurance company. To the extent permitted under applicable law, I authorize release of any information relating to my insurance claims. I hereby authorize payment of the dental benefits otherwise payable to me directly to Steve C. Davis, DMD, P.C.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Accounts past due over 90 days will be turned over to our collection agency.

Broken appointments and cancellations with less than 24 hour notice may be billed at the regular office visit rate.

Agreement to pay: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee including any/all costs of collection agency fees (33.33%), attorney fees and/or court costs if such be necessary. I waive now and forever my rights of exemption under the constitution of the State of Alabama, or any other State.

You agree, in order for us to service your account or to collect monies you may owe, Steve C. Davis, DMD,P.C., and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable

I/We have read this disclosure and agree that Steve C. Davis, DMD, P.C., its employees and/or agents may contact me./us as described above for the purpose of treatment, insurance or payment.

I have read the above conditions of treatment and payment and agree to their content.

_____Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

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.

Signature: _____ Date: _____