PROGRESSIVE FAMILY DENTISTRY

Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We are required by law to maintain the privacy of your health information and inform you of your rights. The Notice contains a section describing your rights under the law related to your personal health information. You have a right to review our Notice of Privacy Practices before signing this consent.

By signing below, I acknowledge that I have reviewed or had explained to me Progressive Family Dentistry's Notice of Privacy Practices and agree to continue my care with Progressive Family Dentistry under said terms.

I authorize the following person(s) to obtain medical information about me or my child and allow medical services to be rendered in my absence

Name: _____ Relationship to Patient: _____ Phone Number: (___)____-_____

Name: _____ Relationship to Patient:_____ Phone Number: (___)_____-_____

_____ _____/_____/_____

Patient or Guarantor Signature Date

Insurance Authorization and Financial Responsibility Disclosure

My signature below authorizes Progressive Family Dentistry to release any medical information necessary to process my or my dependent's insurance claim. I authorize any benefits to be paid directly to Progressive Family Dentistry.

Your insurance company only provides our office with an "estimate" of covered benefits prior to receiving any services or materials from us. This "estimate" is not a guarantee of benefits.

I understand that I may be required to pay a deductible, co-pay or co-insurance for covered services, as well as any balances for services not covered by my insurance plan. In the event that my insurance does not cover for services and or materials rendered to me, I agree to be responsible for the payment of all balances on my or my dependent's behalf for those services and or materials not covered by insurance. I understand that all fees for professional services shall be paid at time of service and are NON-REFUNDABLE. Any returned check may incur a $35 fee.

Progressive Family Dentistry reserves the right to use the contact information provided in this form by you, the patient, to communicate information regarding your account, including attempts to collect on monies owed to Progressive Family Dentistry. We reserve the right to provide your contact information to any third-party for the express purpose of collecting any amounts you may owe for the services rendered. By signing this form, you agree that we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. Method of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Please initial each line below to acknowledge practice policies:

_____ I understand I may be charged a fee for missing an appointment without 24 hour advance notification to cancel.

_____ I understand I may be charged a fee for any forms or paperwork to be completed by the physician.

I certify that I have read and understand the above information to the best of my knowledge.

_____ _____/_____/_____

Patient or Guarantor Signature Date

Consent to Obtain Pharmacy Information Electronically

Progressive Family Dentistry currently participates in the Surescripts system. This allows for the electronic prescribing of medications, which provides a convenience to patients and physicians and also reduces medication error. An additional portion of this service allows for the electronic receiving of medication information such as medications, dosages and prescriptions filled from participating pharmacies. This too, reduces error in medication entry into the medical record and provides your physician with an up-to-date medication profile.

By signing below, you give Progressive Family Dentistry permission to access your information to receive this information electronically for your medical record.

Primary Pharmacy (Name, Street, City, State): _____

_____

Print Patients Name: _____

Signature: _____ Date: _____/_____/_____