CONSENT FOR SERVICES and FINANCIAL POLICY

Thank you for choosing us as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must read and sign this form before seeing the doctor.

As a condition of your treatment by our office, financial arrangements must be made in advance. Our 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.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD,
AMERICAN EXPRESS, DISCOVER, and CARE CREDIT

DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ***ESTIMATED*** co-payment on the day services are rendered. We will gladly file your insurance claim as a courtesy. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions); therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. ***We will gladly file all dental claims for any given treatment but we are not party to any insurance programs or contracts. The balance is YOUR responsibility whether your insurance company pays for your treatment or not. It is your responsibility to inform us of any changes in your insurance coverage.***

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER
All ESTIMATED portions and deductibles are due prior to treatment. In the event YOUR insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

TREATMENT PLAN ESTIMATES
We prepare Treatment Plan Estimates so that patients can understand the estimated cost of their recommended restorative treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to us when the estimate is made. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change.

USUAL AND CUSTOMARY RATES
Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS
Adult patients are responsible for full payment at time of service.

MINOR PATIENTS
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/MasterCard, American Express, Discover, Care Credit or payment by cash or check at time of service has been verified.

NSF CHECK POLICY
Payments made by check that are not honored by the bank will incur a returned check fee of $25.00. The payment will be reversed from the appropriate account when a check is returned by the bank which could result in additional fees being added to the account. A collection letter is sent to the account holder notifying them of the returned item and outlining the consequences of not honoring the item within 10 business days. Returned check reimbursement payments must be in the form of cash, cashier's check, certified funds or money order.

MISSED APPOINTMENTS
We respectfully ask that you give us a minimum of 48 hour notice to cancel or reschedule your reserved appointment and we ask you to reschedule recall hygiene visits within 30 days of your recommended recall schedule. If a patient fails to keep an office visit he or she will run the risk of voiding the warranty on their restorative work or becoming ineligible for their Bleach Clubs refills. Please help us serve you better by keeping scheduled appointments.

ASSIGNMENT OF INSURANCE BENEFITS
I understand that services rendered to me by Dr. Davenport, Associate dentist and Hygienist (collectively labeled as "Provider") are my financial responsibility and that the Provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Provider and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by - 25 days (electronically filed) or 45 days (paper mailed).

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

I also understand that should my insurance company send payment to me, I will forward the payment to the Provider within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event Patient receives any check, draft, or other payment subject to this Agreement, I will immediately deliver said check, draft, or payment to Provider. Any violations of this agreement will, at Provider's election, terminate Patient charge privileges with Provider and bring any balance owed by Patient to Provider immediately due and payable.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I agree to have any photos taken of me to be used for education, training and/or marketing.

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

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Social Security Number: _____

SECTION B: 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: Joanne Latapie
Telephone: 985-768-4520
E-mail: jlatapie@acclaimpm.com
Address: 601 River Highlands Blvd. Suite 200 Covington, La 70433

Agreement as To Resolution of Concerns: I understand that I am entering into a contractual relationship with Doctor for professional care. I further understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of healthcare, and may result in irreparable harm to a healthcare provider. As additional consideration for professional care provided to me by Doctor, I the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against the Doctor.

Furthermore, should a meritorious medical/dental malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use expert witness (es) who practice primarily in the same specialty as Doctor. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Dental Association.

In further consideration for this, Doctor agrees to the same stipulations.

Mutual Agreement to Maintain Privacy: Dr. David Davenport, Associates, Hygienist, and Staff (collectively labeled “We” and “*Dentist”*) agree to provide treatment to “*Patient*”. We take pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, dentists are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. We believe this is improper and may not be in the patients’ best interest. Accordingly, we agree not to provide medical/dental information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, we will never attempt to leverage its relationship with Patient by seeking Patient’s consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of “rating sites” in cyberspace, many fail to provide useful information. Let’s get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

We have invested significant financial and marketing resources in developing our practice(s). Nothing in this Agreement prevents a patient from posting commentary about the Dentist - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication about Dentist, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Dentist for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Dentist’s last date of service to Patient. As a matter of office policy, Dentist is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dentist’s patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Dentist-Patient relationship.

Patient and Dentist acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Dentist agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation. Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, e-mail or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.50 for each page, $20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

BROKEN APPOINTMENT POLICY

When a dental reservation is made in our office, a specific time is reserved for you to see our dentist or hygienist. The appointment allows the dentist to meet your needs and also schedule other equally important patients. Broken appointments result in a loss of valuable time that could be spent with patients in need of treatment and they are very costly to our office.

If a patient fails to keep an office visit he or she will run the risk of voiding the warranty on their restorative work and risk becoming ineligible for their ***Bleach Club*** refills.

We respectfully ask you give us a minimum of 48 hours' notice to cancel or reschedule your reservation and we ask you to reschedule recall hygiene visits within 30 days of your recommended recall schedule.

Please help us serve you better by keeping scheduled appointments.

Thank you for your cooperation.

Signature of patient, parent or guardian: _____

Date: _____

Relationship to Patient: _____

Dental Warranty

Protect your smile

We Stand Behind What We Do. Peace of Mind Limited Dental Warranty

Patient Name: _____Date:_____

We are proud of our dental services and what they do for our patients. Our goal is not to overly correct your dental problems, but have the work we do, last for many years into the future, to save you time and to save you from unnecessary expenses and in addition to show you how to prevent dental disease in the future. The long term success of our dentistry is directly dependent on: How well you care for your teeth at home, eating a sensible diet and adhering to the schedule we set for you for the frequency of your professional examinations, cleaning and fluoride treatments. The products we recommend for you and the frequency of professional continuing care visits depends on your individual situation.

With these thoughts in mind, we are pleased to offer the following limited dental warranty:

Sealants

If our dental sealants are in need of repair with normal use during a period of two (2) years from the date of initial placement, we will replace or repair them at no additional charge.

Composite *(tooth colored)* Fillings

If a composite filling is the *recommended* treatment of choice, we will replace or repair it in the event of a failure for a period of two (2) years. Composite restorations done as a *compromised* form of treatment (instead of a crown, inlay, onlay or veneer) are not covered under this warranty. If the restoration itself (NOT THE REMAINING TOOTH STRUCTURE) breaks or fractures within two (2) years and requires a crown, or onlay, we will credit any out of pocket expense for the filling towards the additional service.

Root Canals

Root Canals are 95% successful but not 100%. If you have a root canal and the recommended final restoration for you tooth (post and core and a full coverage crown) and your root canal fails within two (2) years we will credit your account your total out of pocket expenses of the root canal toward replacement bridge or implant crown.

Crowns, Bridges, Inlays, Onlays and Porcelain Veneers

We have learned that despite our best efforts, any of these tooth restorations can fail for a variety of reasons that include new decay, breakage from excessive grinding of one's teeth, or simply biting down on a hard object such as a fork, bone, or nut. In fairness to both patient and doctor we will warranty these lab created restorations on a sliding scale of replacement cost in the unlikely event that you should require replacement in the first five (5) years. The percentages reflect ***your portion*** of the current fees at the time replacement is needed.

First year	0%	Forth year	60%
Second year	0%	Fifth year	70%
Third year	0%	Sixth+ year	100%

Dentures and Partials

Full Dentures and partial dentures are warranted for a period of two (2) years. Accidents such as dropping your denture are not covered. *Due to the nature of dentures we cannot guarantee your comfort or your ability to accommodate these artificial appliances*. They may require additional services such as adjustments or re-lines to maintain. Those are not included as they are considered maintenance. We will not reconstruct, repair, reline or replace the denture, free of charge, due to any of the following: loss, discoloration, excessive wear (for example, excessive grinding of teeth), inappropriate use (for example, any use not prescribed by the dentist), neglect or abuse.

CONDITIONS

- You must maintain uninterrupted membership in our practice.
- Keep your prescribed regular continuing care appointments (with no appointment carrying more than 30 days), periodontal and regular cleanings.
- Maintain your account in good standing.
- Have all recommended treatment(s) performed by one of our doctors, including the use of bruxism guards if recommended.
- This warranty does not include anything not mentioned above, including gum line desensitization, night guards, nor does it cover damage to teeth or dental prostheses caused by accidents, trauma, neglect or improper use (grinding, clenching, chewing ice or biting non food items)

Patient Signature: _____Date:_____