ACKNOWLEDGEMENT AND RECEIPT OF DR. BRAD M. NEWBERRY, DR. JACOB M. PACK, AND DR. JOSEPH D. MCFARLAND'S PRACTICE POLICIES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment;
- Obtaining payment from third party payers (e.g. my insurance company);
- The day to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

- I have completed the medical history form and have answered the questions truthfully and to the best of my knowledge.
- I authorize the doctor to obtain any necessary medical history or clearance for treatment from my physician(s) or dental insurance carrier.
- I understand that it is my responsibility to advise Endodontics of the Ozarks of any changes in my personal information or medical history.

AUTHORIZATION

- I hereby authorize payment directly to the dental office of the benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I am financially responsible for any balance due and authorize the dentist to release any information required about my dental treatment to third party payers and/or other health professionals. I understand that if it becomes necessary to refer my account for collections, that I will be responsible for all cost of collection; including legal fees and court cost. I also understand that I can be reported to the credit bureau if I fail to meet my obligation.
- I authorize the dental office to administer medications and perform procedures as may be necessary for proper dental care. I certify that I have read and understand the contents of this form and do realize risks and limitations involved.
- By my signature below, I authorize you to discuss or release information, including medical and dental records, x-rays, history, findings, and prognosis pertaining to my condition or service/treatment rendered to me via email, or fax with my referring dentist.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE