CONSENT FOR SERVICES

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or her staff, I agree to pay the reasonable value of said services to said Doctor, or assignee, at the time said services are rendered, or within five (5) days of billing, unless previous financial arrangements have been made.

All dental services must be paid at the time the services are performed. Minor children, he parent or guardian who brings the minor in for treatment will be responsible for payment of services performed at time of service.

I understand that this office will help prepare my **PRIMARY and SECONDARY** insurance forms to assist in making collections from that insurance carrier and will credit such collections to my account. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges.

A billing charge of 1 1/2 % per month (18% per annum) (but in no event more than the maximum rate permissible under state law) or $15.00 minimum per month will be charged on the unpaid principle balance (including insurance payment due) on all accounts not paid within 60 days of treatment date. As a courtesy to you we will submit to your dental insurance. If your dental insurance company does not pay after the second submission, you are responsible for payment on account.

My account will subject to collections if not paid within 60 days, I will be held responsible for all attorney/collection fees incurred from this debt.

CANCELLATION POLICY

I understand that a minimum of $25.00 will be charged to my account for any appointment cancelled or rescheduled within a 24 hours of my original scheduled appointment time. Any appointment in which I do not arrive for and no notice was given to Dr. Lindsey, there will be a $25.00 (minimum) fee charged to my account. These fees must be paid before any additional appointment can be scheduled. If there are 3 or more appointments cancelled or broken within a 1 year period, Dr. Lindsey holds the right to no longer see me as a patient.

HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of consent: By signing this form, you will consent to your use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. Notice of Privacy Practices: You have 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 use and disclosures we may make of your protected health information and of completely before signing this consent. You have the right to revoke this consent at any time by giving us written notice of you revocation. Please understand that revocation of this Consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decline to treat you, or continue treating you if you are revoked.

PHOTO RELEASE

I grant Lindsey Dental, its representative and employees the right to take photographs of me and my mouth. I authorize Lindsey Dental, its assigns and transferees to copyright use and publish the same in print and/or electronically. I agree that Lindsey Dental may use such photographs of me without my name and for any law purpose, including for example such purpose as publicity, illustration, advertising and web content.

X_____

Signature of patient/responsible party or guardian **Date**

X_____

Print Name