NEWPORT FAMILY DENTAL CARE, P.C.

This document contains very important information and disclosures that you need to understand and accept before any dental service can be provided. There are two subjects covered. First, you need to understand how we handle your private information. The second subject has to do with how we handle our dental services. This includes financial arrangements, dental insurance, and scheduling of appointments.

Notice of Privacy Practices Acknowledgement

Version 1

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

INFORMED CONSENT INFORMATION

I certify that I have read and understand the previous information and the previous questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me (or my dependent) during the period of such dental care to third party payors and/or health practitioners. I agree to be responsible for payment of dental services.

REGARDING PAYMENT FOR SERVICES

I understand that I will be asked to make financial arrangements at the time I schedule an appointment for any dental treatment that is required. With or without insurance payments, balances not current will be subject to finance charges of 18% annually (1.5% monthly) with a minimum finance charge of .50 per month. I understand that I will be promptly reimbursed when my insurance company sends payment. I am also responsible for any court cost or attorney's fees should my (or my dependents) account become default and be placed for outside collection, and at that time a minimum charge of $30 and up to 66% of the balance will be added to the remaining balance. I understand that there will be a $25.00 fee for a returned check. Also, I authorize any credit balances under $25.00 will remain on my account for future services.

SEE BACK SIDE

I authorize and request my insurance company to pay directly to the dentist or dental group the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that my insurance contract is between my employer, the insurance company and myself. I understand and agree that I am responsible for notifying this office of any changes in my insurance status. In order to expedite my insurance processing, my claims will be processed with the aid of a computer. Therefore, I know it will not be possible for me to sign every form. I authorize your office to place the words "Signature on File" in the blanks that request my signature.

I understand that the staff of NFDC, P.C. is not an agent of any insurance company. Therefore, any insurance information from them may not be accurate and I do not hold them accountable.

I understand that it is necessary to give two business-days notice to make a change in a scheduled appointment (unless I have an emergency) and that I will be charged for 25% of the cost of the visit if I fail to do so. In addition, I will be asked to leave a 25% deposit in the form of cash, check, or credit card to secure my future appointments. I understand that the deposit goes toward my scheduled appointment fees. I understand that if I miss a secured appointment, I will forfeit my security deposit except in the event of an emergency.

I authorize photographs to be taken of my (or my dependents) dental conditions. I understand that these photographs will be used as part of the clinical records for documentations, education, and commercial purposes.

I authorize dental services to be rendered by Newport Family Dental Care, P.C and its staff and agree to the above information.

YOU WILL BE ASKED TO SIGN ELECTONICALLY TO SHOW THAT YOU HAVE READ, UNDERSTAND AND AGREE TO THE INFORMATION IN THIS FORM.