Consent for Internet Communications

I grant my permission to D. Bryce Alldredge, DMD, PC, (hereafter Dentist) and/or such associates or assistants to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured website for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Patient Name: _____

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Relationship to Patient: _____

(Rev. 4/5/12)

Consent to Proceed

I authorize D. Bryce Alldredge, DMD, PC, (hereafter Dentist) and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally, drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of radiographs to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand it is necessary to disclose to the Dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I have read the above conditions of treatment and hereby agree to abide by the conditions outlined herein.

Patient Name: _____

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

Relationship to Patient: _____

(Rev. 4/5/12)

Financial Policies and Federal Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that the charges will be paid in full by an insurance company. If we do not receive payment from your insurance company within 30 days, you will be responsible for payment of your treatment fees and the collection of your benefits directly from your insurance carrier.

A service charge of 1.5% per month (18% APR) on the unpaid balance will be assessed on all accounts exceeding thirty (30) days from the date of service unless previously written financial arrangements are made. There is a $5 late payment fee. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination. A fee of $30 is charged for patients who miss, cancel, or reschedule without 36-hours of notice, excluding weekends and holidays. If you do this three times, you will be dismissed from the practice. This is our *Three Strikes, You're Out Policy*. A fee of $50 is charged if the missed appointment is an evening or Saturday appointment. If you miss one of these special appointments, you will not be given another one. There is a fee of $25 for returned checks.

In consideration for the professional services to be rendered to me (or at my request, to my minor child or ward) by D. Bryce Alldredge, DMD, PC (hereafter Dentist), I agree to pay the fees charged for the dental services provided by the Dentist or licensed employee at the time the services are rendered, or within ten (10) days of billing if credit is extended by the Dentist. In the event my account becomes delinquent, I the undersigned agree to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing forty (40%) of the principal balance if the account is referred to a collection agency or attorney for collection. This additional amount is in recognition of the costs associated with said collection action processing. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the Dentist's collection agency or attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the Dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted. I also authorize payment directly to D. Bryce Alldredge, DMD, PC, of the Group insurance benefits otherwise payable to me.

I acknowledge that I have been offered or received a copy of the Notice of Privacy Practices from this Office. I understand that I may request a copy of the Notice of Privacy Practices at any time. I am also aware that I can download a copy from this Office's website.

I have read the above conditions and hereby agree to abide by the conditions outlined herein.

Patient Name: _____

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

Relationship to Patient: _____

(Rev. 4/5/12)