CAPITAL DENTAL, INC.
1771 Lelia Drive
Jackson, MS 39216

In an effort to keep the cost of dental services down and help eliminate confusion about your account, CAPITAL DENTAL, INC. would like to reiterate its financial policies. PLEASE READ AND SIGN.

1. I, the undersigned consent to an examination (physical, photographic and/or radiographic x-ray) of me or my dependent by Dr. Lewis Grubbs or Dr. William E. Umphlett, for the purposes of diagnosis of any afflictions for which I may or may not have sought treatment. I understand that treatment recommendations may be made and discussed and it is my right and duty to decide whether or not to accept and follow those recommendations or alternative recommendations that may be made. I understand that failure to follow prescribed course of treatment may be against my best interest and I accept full responsibility for my decision and actions.

2. I understand that this is a fee-for-service practice and unless there is a PRIOR AGREEMENT, ALL FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. We accept cash, check, most major credit cards and CareCredit financing. I understand that a service fee of $15.00 may be assessed on any past due accounts and an interest charge of 1.5% per month or 18% per year may be assessed on any accounts greater than 90 days past due. THIS WILL APPLY TO ALL ACCOUNT BALANCES INCLUDING THOSE THAT EXIST WHEN INSURANCE COMPANIES DELAY MAKING THEIR PAYMENTS. I agree to pay any reasonable costs incurred by CAPITAL DENTAL, INC. in attempting to collect past due accounts as are due from me including legal fees and court costs. I understand that there will be a $20.00 service charge for any returned checks.

3. CONCERNING DENTAL INSURANCE, Dental services are recommended and provided for you, the patient. The patient is responsible for the ENTIRE FEE for services they accept. Dental insurance is a benefit that your employer provides you to assist in paying for dental cost. Filing your dental insurance is a benefit our office provides you, not a responsibility of our office. Dental insurance does not release you from your financial responsibility for the dental treatment that you have accepted. YOU ARE ULTIMATELY RESPONSIBLE FOR ANY AND ALL FEES DUE. For any claims to be filed we must have accurate up to date insurance information and we will provide all necessary information regarding the dental treatment. If your claim is returned to us because of incorrect information that you have provided then there may be a $15.00 service charge to cover the cost of refilling. The insurance company works for the patient not the dentist, when there is a dispute on a claim it is the patient's responsibility to settle the difference with the insurance company. We will provide you with any information you may need in your discussion with them. It has been our experience that insurance companies will respond quicker to the patient's request than ours.

4. I warrant that any and all answers that I may give relating to identification, insurance information, medical history and treatment follow-up shall be truthful to the best of my knowledge.

We thank you for your cooperation on implementing these policies.

Patient/Guardian Signature _____ Date_____

CAPITAL DENTAL, INC.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME_____
ADDRESS_____
TELEPHONE _____ EMAIL _____
PATIENT # _____ SOCIAL SECURITY # _____

SECTION B: TO THE PATIENT
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 reserve the right to change our privacy practices as describe 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 CAPITAL DENTAL, INC. 601-362-2660, 1771 Lelia Drive, Jackson, MS 39216.

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 the 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 healthcare 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 _____