PATIENT CONSENT, AGREEMENT AND AUTHORIZATION

I authorize the office of Robert A. Claypoole, D.M.D. and Robert A. Claypoole, D.M.D. to use and disclose information in my dental records for treatment, payment and health care purposes. I understand that the information in my dental records may be used and disclosed to other people to carry out their responsibilities in connection with my dental treatment, in payment for dental care services and activities related to dental care.

I understand that if dental treatment is necessary. I will hereby consent to authorize administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of Robert A. Claypoole, D.M.D. I reserve the right to refuse any and all treatments.

I understand and agree that I am ultimately responsible to pay the charges for all services rendered to me. I understand, that if for some reason, under my insurance guidelines a service is determined to be non covered, partially paid, or denied. I will be responsible for the payment. _____Initial.

I request that payment for authorized insurance benefits be made on my behalf to Robert A. Claypoole, D.M.D. for all services rendered to me by said individual. Photocopy of this authorization shall be considered effective and valid as the original.

If I am pregnant or planning to become pregnant over the next year, if I am currently using birth control or breast feeding, it is my responsibility to inform Robert A. Claypoole, D. M. D. of these facts or intentions.

I have read the above statements, understand and agree to them. I understand that they are a permanent part of my file. Should I wish to rescind my authorization, I must do so in writing.

I acknowledge that I have received this Notice of Practices for Protected Health Information from the dental office of Robert A. Claypoole, D. M. D, P C

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Signature of Patient or Patient Representative Date

_____ _____

Printed Name of Patient Patient's Date of Birth