Thank you for choosing our office to serve your dental needs. We have listed our office policies for your convenience, and would appreciate the extra time that it may take to review them.

PRIVATE PAY PATIENTS (No Insurance)
We ask that all private pay patients pay in full at the time of service. For your convenience we accept Cash, Master Card, Visa, Discover, American Express, CareCredit or Personal Check. There will be a $20.00 charge on all returned checks.

PRIMARY INSURANCE
As a courtesy, we do submit insurance claims. We request the deductible and co-payments be paid at the time of service. Should the account exceed 60 days with no response from your insurance company, we do expect the account to be paid in full by you.

SECONDARY INSURANCE
If you have a secondary insurance coverage, we will be more than happy to take your information and forward the claim for you to the secondary carrier. However, turnover for payment is 4-6 weeks per insurance company, therefore, we still ask that the account be paid in full within 60 days.

MINORS (Children under 18)
The person financially responsible by law for a child's visit, is the person which brings the child to the dentist. We understand that sometimes there are situations such as divorce in which a different parent has been ordered to pay medical / dental expenses. We will be more than happy to provide an estimate for services in advance so that the amount can be collected prior to treatment. We will also bill the responsible party following insurance payment, however, if payment is not received within 60 days we will expect payment in full, by the adult who attends the dentist with the patient. We will be happy to provide you with a proper receipt in which to take the responsible party to litigation.

CANCELLING APPOINTMENTS
We strive to treat our patients as quickly and conveniently as possible, however, we do schedule sometimes a month in advance. Patients in pain are often placed on an emergency list and are waiting for canceled appointments. For this reason we ask that you allow us enough time to fill your slot in our schedule if you are unable to keep your appointment. Due to this reason we will charge a $45.00 fee for any appointment not canceled within 24 hours of scheduled time. We understand that sometimes appointments are overlooked or emergencies interfere, however if you miss 3 appointments without canceling your chart will be closed to our office.

ADDITIONAL FAMILY MEMBERS
We try to stick to our schedule as closely as possible. We have limited space available in our exam rooms, therefore, we ask only one adult accompany a child to the room. We would prefer that adults go back alone. Should special circumstance apply, please see our receptionist.

SERVICE CHARGES
There will be a $3.00 charge added to each account if it exceeds 60 days. This also includes accounts which the insurance has not yet made payment. The average turn around for insurance payment is 4-6 weeks. If your insurance has not made payment within this time, the balance is due and payable by the patient and is still eligible for interest.

CONTACT INFORMATION
There are times that we need to confirm an appointment or speak to you about your account. Should you not be available at the numbers listed on your health history and we reach an answering machine, we need your permission to leave a message. By signing this paper, you are giving us permission to do so. Should you not want us to leave a message on your answering machine, please initial over this section.

QUESTIONS
Please feel free to ask any questions that you have about our office. We appreciate the fact that you have chosen us and we hope that you enjoy your visit with us. Patient comfort and quality dentistry is our main concern.

If you have read the above policies and understand them to be true for this office, please sign below.

Signature _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Address: _____

Telephone: _____ E-mail: _____ Patient Number: _____

Social Security Number: _____

Section B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described 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: Michele Linville Telephone: 304-369-2034 Fax: 304-369-3086 E-mail: drhowell@ntelos.net or Snail Mail Address: 407 State Street Madison, WV 25130

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 this 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 heath care operations. Signature: _____ Date: _____

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*******SIGN BELOW ONLY IF YOU DO NOT GIVE PERMISSION TO RELEASE INFORMATION - REVOCATION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent. Signature: _____ Date: _____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

(2 sides)

Acknowledgement of Receipt of Notice of Privacy Practices

****You may Refuse to sign this Acknowledement****

I have been notified that Dr. Howell will only release my personal information for the purpose of treatment or payment. Private information is released in instances of insurance billing and referral to labs or specialist.

(Please intial below if you agree with the following)

The telephone numbers I've given the office can be used to contact me regarding appointments and my account. In the event that there is no answer, a message can be left on the answering machine. _____

(Please Initial)

If I am not available, you may discuss my appointment or account with the following people:

Name Phone number

_____

_____

_____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign _____**
- **Communications barriers prohibited obtaining the acknowledgement _____**
- **An emergency situation prevented us from obtaining acknowledgement _____**
- **Other (Please Specify)**

_____