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DENTAL SERVICE ARBITRATION AGREEMENT

The dentist whose name appears below agrees to provide to the undersigned patient dental, surgical and related health are services in consideration for the payment on a fee for service basis.

ARTICLE I

It is understood that any dispute as to dental malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE II

Said agreement for arbitration as provided in Article I above shall apply to the dentist, agents, representatives and employees, successors in interest and staff dentist of the dentist and the patient "whether or not a minor" his heirs-at-law, personal representatives and any claim in tort, contract or otherwise the other of demand for arbitration of any controversy, the parties to the controversy shall each appoint an arbitrator and give notice has been given, the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection of the neutral arbitrator. All notices or other papers required to be served shall be served by U.S. MAIL.

ARTICLE III

The dentist named below agrees only to provide such services as in his opinions are reasonable, necessary and appropriate. Should patient for reasons personal to him/herself refuse to accept the procedures, medicines or course of treatment recommend by the dentist, and if the dentist believes that no professionally acceptable alternative exists, and after being so advised that patient refuses to follow the recommended treatment or procedure, then the patient shall be given no further treatment and the dentist shall have no further responsibility to provide services specified herein for the condition under treatment.

ARTICLE IV

This agreement may be terminated only if written notice is given by the patient within thirty (30) days from the date patient executes this agreement and is no such notice is given, the agreements herein concerning arbitration shall be binding and compulsory.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE AN ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL (See Art. I of this contract)

DATE:_____

PATIENT: _____

SIGNATURE:_____

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MEDICAL HISTORY

*Patient Name:*_____*Birth Date:*_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking , could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	YES	NO	If yes, please explain _____
Have you ever been hospitalized or had a major operation?	YES	NO	If yes, please explain _____
Have you ever had a serious head or neck injury?	YES	NO	If yes, please explain _____
Are you taking any medications, pills, or drugs?	YES	NO	If yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux?	YES	NO	_____
Are you on a special diet?	YES	NO	_____
Do you use tobacco?	YES	NO	_____
Do you use controlled substances?	YES	NO	_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/ Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/ Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had a serious illness not listed above? YES NO If yes, please explain: _____

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date:_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPPA"), 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 heath care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal heath care operations such as quality assessments and physician certifications.

I have received, red and understand your NOTICE OF PRIVACY PRACTICES contains a more complete description of the uses and disclosures of my heath information. I understand that Dr. Carter has the right to change his NOTICE OF PRIVACY PRACTICES.

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

PATIENT NAME: _____

SIGNATURE:_____ DATE:_____

OFFICE USE ONLY:

I have attempted to obtain the patient's signature in acknowledgement on the NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as documented below:

DATE: _____ INITIALS: _____

REASON:_____

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APPOINTMENT AND FINANCIAL POLICY

A 24 hour notice is required for all appointment cancellations. I understand that I will be responsible for a $50.00 charge for all appointments cancelled less than 24 hours. The $50.00 charge will also apply to any missed appointments in which our office was not notified.

Payment options: Please indicate your method of payment below

☐ MasterCard ☐ VISA ☐ AMERICAN EXPRESS ☐ DISCOVER NETWORK ☐ CHECK

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. I authorize the dentist to release any information including diagnosis and the records of treatment rendered to my dependents or me during the period of dental care to third party payer and or health practitioners. I authorize my insurance carrier to pay directly to the dentist. I understand that my insurance may pay less than the actual bill for services and that I will be responsible for payment in full of all remaining balances for services rendered on my behalf and/or that of my dependents regardless of insurance coverage. I further understand that the dental insurance is filed as a courtesy to me. All claims over (30) thirty days that are not paid, will be my responsibility and the balance will be due in full at this time.

I further understand that should I fail to pay my account balance, I will be responsible for all the collection charges incurred, including 40% collection agency fees if placed with a collection agency, plus reasonable attorney fees and court cost if legal action is instituted to enforce collection of any balance owed.

I certify that I have read the above information and fully understand and agree to these terms.

AUTHORIZED SIGNATURE:_____

DATE:_____

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PATIENT AUTHORIZATION FORM

I hearby authorize Dr. Michael Carter and Dr. Catherine Sledge to use or disclose the specific information described below, only for the purposes and parties described below:

1. Information requested by patient's insurance company to process claims.
2. Information requested by providers in which the patient has been referred to this office for further treatment
3. Patient records requested by patient or patient's representative.

This authorization shall remain in effect beginning date this document was signed and will expire only by written notice.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, Attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer by protected by HIPPA

- I may refuse to sign this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.

PATIENT NAME: _____

SIGNATURE:_____

RELATIONSHIP TO PATIENT: _____
(*If signed by personal representative of patient)*

DATE:_____

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