SHETEK DENTAL CARE

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

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:

Contact Person: NARLA HULSTEIN

Telephone: 507-836-1000 Fax: 507-836-1008

E-mail: hulstein@shetekdental.com

Address: Shetek Dental Care, 2711 Broadway, Ave. Slayton, MN 56172

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.

CONSENT FOR TREATMENT & AUTHORIZATION AND RELEASE OF INFORMATION

Consent for Treatment: I do hereby voluntarily consent to Shetek Dental Care for dental care and treatment. Although this entity has agreed to provide me with the best care possible, I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examinations by this facility.

Authorization and Release: I certify that I have read and understand this information and have answered all questions truthfully and to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize my insurance company to pay directly to Shetek Dental Care any insurance benefits otherwise payable to me. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or practice has a contractual agreement with the plan prohibiting all or a portion of such charges.

All patient accounts will be considered due upon date of service unless other financial arrangements have been made. As a courtesy to me, Shetek Dental Care will process my insurance if proper information is provided. I agree to pay my estimated portion and /or co pay on the date that services are rendered. Interest will be charged at a rate of 1.5% per month on all unpaid balances aged 30 days after date of service or 30 days after third party payer pays.

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. **YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

Signature of patient or patient's personal representative and Date:

X