JOHNSON PEDIATRIC DENTISTRY MEDICAL INFORMATION RELEASE

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of Johnson Pediatric Dentistry and that Johnson Pediatric Dentistry may release all or portions of my dental record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker's compensation carriers. I further acknowledge that Johnson Pediatric Dentistry may disclose my patient information to referring or treating health car providers, and for payment and health care operations. I hereby authorize Johnson Pediatric Dentistry to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, films/images, and other clinic information deemed necessary by Johnson Pediatric Dentistry physicians or representatives. I understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations in accordance with Johnson Pediatric Dentistry's privacy policy.

PATIENT NAME:

PARENT / GUARDIAN SIGNATURE DATE:

In addition to myself I authorize the release of records to the following individuals for the patient listed above.

NAME: RELATIONSHIP TO PATIENT:

NAME: RELATIONSHIP TO PATIENT:

CONSENT FOR TREATMENT

I hereby consent to the dental treatment, diagnostic, and other procedures, which the dentist may deem advisable in treatment of my case (or as legal guardian for patient). Johnson Pediatric Dentistry will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

PATIENT NAME:

PARENT / GUARDIAN SIGNATURE DATE:

CREDIT AND FINANCIAL CHARGE POLICY AND AGREEMENT

I hereby authorize any benefits due me to be paid directly to Johnson Pediatric Dentistry, 772 N Dixie Drive, Suite 101, St. George, UT 84770. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non medically necessary" by my third party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

A finance charge (1.5% per month/APR 18%) may be added to my amount for which payment has not been received within 60 days from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of $20.00 for each check or other instrument tendered by me but returned to this facility. Additional service charges may be levied for accounts placed with third-party collections agencies, or failure to make necessary co-payments at the time of service.

It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs incurred for collection of this account.

In consideration for dental services rendered, I (we) acknowledge that I (we) have received notice of Johnson Pediatric Dentistry's financial policy and agree to pay for said dental services according to such terms.

I hereby expressly consent to receiving voice and SMS (text) messages (including pre-recorded messages) on my mobile phone number and any other telephone number(s) that I provide (either directly or through and intermediary) to Johnson Pediatric Dentistry or any of its affiliates, agents, or contractors (including third-party billing and/or collection companies). I understand and agree that such messages may be sent by Johnson Pediatric Dentistry and/or by is affiliates, agents, or contractors and may be sent via automated dialing technology (i.e. auto dialer) and may consist of such things as appointment reminders, treatment plan scheduling, notices and/or collection efforts.

PATIENT NAME:

PARENT / GUARDIAN SIGNATURE DATE: