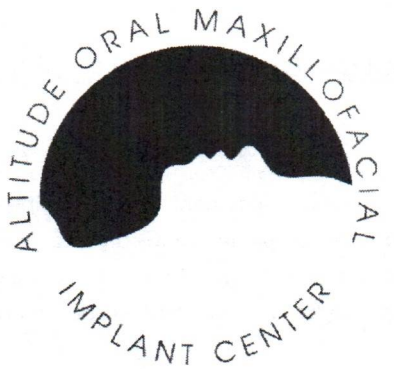

Date: _____

To Our Valued Patient:

As mandated by Federal Law, Altitude Oral Maxillofacial Implant Center has made me aware of the HIPAA (Health Insurance Portability and Accountability Act) Laws. HIPAA Privacy Posters are posted in the office, and I have taken the time to read and understand that my personal health information will be used only for the purposes of providing treatment, obtaining payment from my insurance company, and conducting health care operations. I understand that I have the right to obtain a copy directly from Altitude Oral Maxillofacial Implant Center at any time.

Please be advised that in the event of surgery, whoever has escorted you may be exposed to your health information and post-op instructions.

Please list contact numbers:

Home: _____ Cell: _____

Would you like us to leave a message? _____

Please list anyone authorized to speak with us about your health information: _____

_____

_____

Patient/Parent or Guardian Signature

_____

Patient/Parent or Guardian Printed name

BRIAN FANGMAN, DDS

Board Certified Oral & Maxillofacial Surgeon

LODO: 1440 blake street, suite 100 | denver co 80202 | o: 720.328.4990 | f: 720.328.4994 | www.altitudeoms.com

CHERRY CREEK: 155 cook street, suite 241 | denver co 80206 | o: 720.328.4990 | f: 720.328.4994

Altitude Oral Maxillofacial Implant Center

Please read and initial each line

_____ 1. Patients are responsible for payment, co-payment, and deductibles at time of service. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account. A credit card will be kept on file for any outstanding balance.

_____ 2. In addition, I assign directly to Altitude Oral Maxillofacial Implant Center all surgical and/or medical benefits, if any, otherwise payable to me for services rendered.

_____ 3. I also verify that all the information contained on these information sheets is true and correct, to the best of my knowledge and belief. I authorize Altitude Oral Maxillofacial Implant Center to release my complete records to my insurance company in order to process my claim and for any other physicians or medical facilities that may be pertinent and necessary to care treatment.

_____ 4. I understand that ALL biopsies will be sent to a 3rd party lab. We are not affiliated with them, and separate fees will occur. They will bill medical insurance, which may be out of network.

_____ 5. An adult must accompany children under the age of 18 at all times.

_____ 6. Due to the nature of our practice, we ask that you do not consume food in our reception area.

Cancellation

_____ 7. Please call to reschedule or cancel any appointment within 48 hours.

Records Duplication

_____ 8. We are required by law to keep all originals. There may be a fee of up to $50.00 for any record duplication. Please ask front desk for details.

_____ 9. Protecting your confidential health information is important to us.

_____ 10. As mandated by Federal Law, Altitude Oral Maxillofacial Implant Center has made me aware of the HIPAA (Health Insurance Portability and Accountability Act) laws. I have taken the time to read and understand that my personal health information will be used only for the purposes of providing treatment, obtaining payment from my insurance company, and conducting health care operations.

_____ 11. HIPAA Privacy Posters are posted in the office, and I have the right to obtain a copy of the information directly from Altitude Oral Maxillofacial Implant Center at any time.

I have read and understand the above statements.

Patient or Parent/Guardian Signature: _____

Printed Name: _____ Date: _____