PATIENT CONSENT/ ACKNOWLEDGEMENT FORM

Kenneth B. Hashimoto, D.M.D. has been practicing Dentistry for over 30 years in the beautiful town of Sacramento. We strive to make your dental visits as comfortable as possible. We're never too busy to meet new friends! Here is what you can expect on your first visit:

We'll take the time to know you, as well as your likes and dislikes regarding past dental care. We'll carefully review your medical history. We will screen for oral cancer and periodontal (gum) disease. From there, we will examine your teeth and take any necessary x-rays and photos. We will work together to establish a treatment plan that best meets your needs.

Please assist us by providing the following information at the time of your visit:

- Any current x-rays (taken within the last year). You may also provide us with the name and phone number of your previous office so we may contact them to have them email electronic x-rays and patient history.
- A list of medications you are currently taking.
- If you have dental insurance, bring your insurance card or documentation.

PATIENT CONSENT/ ACKNOWLEDGEMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Kenneth B. Hashimoto, D.M.D., our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice").You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting our office at 916-393-2231 to request a revised Notice. We will also post any revised notice at our office which is located at 7210 South Land Park Dr. Suite B, Sacramento, CA 95831.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH REPORT TO OBTAIN THAT ACKNOWLEDGMENT.

PLEASE SIGN BELOW STATING YOU HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

X_____ _____

Patient or Responsible Party for under 18 Signature Today's Date

CONSENT FOR TREATMENT

I hereby grant authority to Kenneth B. Hashimoto, D.M.D. to administer such necessary x-rays, anesthetics or sedative and to perform such operations as may be deemed advisable in their diagnosis and treatment.

I hereby state that the medical and dental histories are correct to the best of my knowledge. I authorize routine dental diagnostic procedures. I also agree to the use of anesthetics and medications considered necessary or advisable by the Dentist or his supervised staff. I understand I am responsible for any collection fees/costs if it is necessary for my account to be sent to a third party for collection. I understand that it is a courtesy for the dental office of Kenneth B. Hashimoto, D.M.D. to call my insurance for benefits but it is ultimately my responsibility to verify all information before any dental visit.

I understand the consequences of **NOT** having the needed dental treatment completed.

Dental Material Facts Sheet

I, acknowledge I have received or reviewed a copy of the Dental Material Fact Sheet dated May 2004 from Kenneth B. Hashimoto, D.M.D.

X_____ _____

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Payment is due when services are rendered. Thank you.

APPOINTMENT GUIDELINES

To keep the cost of dentistry as low as possible, appointments are scheduled to best fit the patient's time, and the Doctor or the Hygienist's time. These appointments are a contract of time reserved especially for you.

If it becomes necessary to reschedule, (and we understand emergencies occasionally occur) you need to contact us **48 HOURS IN ADVANCE** to give us an opportunity to offer the time to another patient that is waiting.

If 48 hours notice is not given, a verbal reminder of our policy will be given on the first and second instances, the third time will result in our invitation for you to find another dentist that can better accommodate your schedule.

Thank you,
Kenneth B. Hashimoto, D.M.D.

PLEASE SIGN BELOW STATING YOU HAVE REVIEWED, UNDERSTAND AND AGREE TO THESE APPOINTMENT GUIDELINES.

X_____ _____

Patient or Responsible Party for under 18 Signature Today's Date

FINANCIAL POLICY – INSURANCE POLICY FORM

FINANCIAL POLICY

Payment is expected at the time of service. If you have dental insurance, claims are processed as a courtesy to you. Deductibles and estimated co-payments are due at the time of service. The co-payment estimates are based on information provided by your insurance company. If there is any co-pay due after the insurance payment you will receive a statement to send in the additional amount owed. Major treatment procedures, requiring more than one visit, i.e., crowns, bridges, partial or full dentures we ask half of the fee at the first appointment and payment in full by the time the prosthesis is placed in your mouth. We are a health care provider and do not work as a financial institution providing financing. We accept cash, checks, and major credit cards as well as offering a financing plan through Care Credit. Regardless of insurance coverage, you are ultimately responsible for payment for treatment. If balance becomes 90 days delinquent and is not resolved your account will be turned over to a third party for Collections with a $35.00 Collection Fee added to the account balance. Your contract of coverage is with your insurance company rather than with Kenneth B. Hashimoto, D.M.D. **You are responsible to notify us of any changes to your insurance occur**. If not notified we will use the current information on file to file your claims.

If you would like additional information on Care Credit please ask the front desk or visit their website at www.carecredit.com.

INSURANCE POLICY

If you have insurance coverage and would like us to submit claims for you, we will do so if you provide us with complete information. It is **ALWAYS** your responsibility to verify eligibility with your insurance carrier. **You are responsible to notify us if any changes to your insurance occur**. Most companies provide all information to you regarding your benefits. If you have questions, we will be happy to assist you in understanding your coverage if you bring a benefits booklet to our office. **Please be aware of your yearly maximum benefits and deductible**. Our assistance in processing your insurance claims in no way implies responsibility for payment. If you feel your claim is not paid in a timely manner, please contact your insurance company to verify that the claim was received and processed. If we need to resubmit a claim you may request us to do so.

Information needed to process claims includes the subscriber's name, address, phone, birth date, social security number or insurance id number, employer name, employer address and phone #, group number, and finally the insurance company name address and phone number.

We will submit a request for prior approval on any procedure you wish and some major procedures we routinely pre-authorize. Please be aware, however, that a pre-authorization is **NOT** a guarantee of payment by your insurance company. All insurance is processed on a daily basis. By law, insurance companies are required to pay within 45 business days of service. If insurance payment is not received in our office after 60 days, the balance expected from the insurance company is then due from you at that time. We will continue to assist you by resubmitting the claim as needed so you may be reimbursed by the insurance carrier.

PLEASE SIGN BELOW STATING YOU HAVE REVIEWED, UNDERSTAND AND AGREE TO THE FINANCIAL AND INSURANCE POLICY.

X_____ _____

Patient or Responsible Party for under 18 Signature Today's Date