

**Bright Smiles Dental Inc.**  
**Patient Agreement & Acknowledgement**

Adel V. Myrie, D.M.D.

Robert A. Toney, D.M.D.

1. **PATIENT' RIGHTS**: Patient or representative has received or has been offered a copy of Bright Smiles Dental Inc.'s Notice of Privacy Practices. \_\_\_\_\_ (Initial)
  
2. **LEGAL STATUS**: Patient is 18 years of age or older or legally emancipated if under 18 years of age. \_\_\_\_\_ (Initial)
  
3. **ASSIGNMENT OF INSURANCE RESPONSIBILITY**: I hereby authorize payment of all insurance benefits for services rendered to be made directly to Bright Smiles Dental Inc. If the check must be made out to me, I agree to send the payment to Bright Smiles Dental Inc., at 8371 Hwy 72 West, Suite #208, Madison, AL 35758. \_\_\_\_\_ (Initial)
  
4. **STATEMENT OF FINANCIAL RESPONSIBILITY**: I hereby agree to pay Bright Smiles Dental Inc., for all charges not covered by my insurance company. I also agree to pay any additional fees associated with collections if I fail to pay my outstanding balance including reasonable attorney fees or collection agency fees. \_\_\_\_\_ (Initial)

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**CONSENT FOR DENTAL TREATMENT**: I hereby consent to and authorize Bright Smiles Dental Inc., to render usual and customary dental treatment, including x-rays, surgical procedures, and other general dentistry treatment considered advisable or necessary by the dentist.

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**Acknowledgement to Use and Disclose Health Information for Treatment, Payment, or Healthcare Operation**: I have received or have been offered a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that Bright Smiles Dental Inc., reserves the right to change its notice and practices, and will provide me with a revised notice if changes are made.

The signature below applies to items and terms indicated above. I have read and understand the above and I have willingly signed this document.

X \_\_\_\_\_  
Signature of Patient or Authorized  
Representative

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Requested Restrictions**: I understand that I have the right to request Bright Smiles Dental Inc., to restrict how the practice uses protected health information about me to carry out treatment, payment, or other health care operations. The requested restrictions