C. Ben Lennon DDS, INC (Referred to as CBL throughout this document)

Patient Consent and Financial Responsibility Agreement

As a patient of CBL, I agree to the following:

- **Dental Treatment Risks**: I acknowledge that all dental treatment involves some risks and that no guarantees can be given regarding the outcome.

- **Release of Prescription History**: I authorize any dentist treating me on behalf of CBL to request and receive any and all information regarding my medication history including information maintained by the Virginia Prescription Monitoring Program.

- **HIV Testing Disclosure**: Under Virginia law, if any employee of CBL comes in contact with your blood or body fluids during your care, CBL has the right to require you to have a current HIV and Hepatitis B or C screening. The law also requires that the results of these tests be released to the person who is exposed to your body fluids without your consent.

- **Financial Responsibility**: I assign any benefits to CBL that I may have for reimbursement for my dental treatment received at CBL which I may be entitled to from any insurance coverage, workers compensation benefits, and all settlements, judgments and verdicts against any liable third party. If I fail to pay outstanding CBL balance, I understand CBL will have a lien against any such settlement, judgment or verdict equal to the full amount of my CBL bill. I further direct any attorney handling or disbursing such proceeds to withhold and promptly pay to CBL the full amount of any outstanding balance owed by me, the patient, to CBL for dental services rendered. I also understand and agree to pay a $30 fee incurred for any returned checks.

- **Balances:** Should I receive a bill from your office, payment in full o fhte Guarantor's balance is due by the date indicated, unless other arrangements have been specifically made in writing in advance. Any co-payfor covered sercices and fees for non-covered services are due at the time of visit. I acknowledge that payment of all balances is due prior to my next appointment.

- **All Payments Due at Time of Service**: While CBL, as a courtesy to patients, will bill most insurance companies; CBL is under no obligation to do so. If your insurance company fails to pay all or part of your bill, you are responsible for all charges. By signing this agreement, I agree to accept full responsibility of all CBL charges. Full payment is required at time of service; CBL reserves the right to charge interest at a rate of 12% from the time of delinquency on any outstanding balance. In addition to interest, I agree to pay both any reasonable collection agency and/or attorney fees associated with recovering any outstanding balance. I agree this agreement is an original, direct, independent promise to pay based on the independent credit worthiness of the patient or responsible party, and is not a collateral or contingent promise to pay the debt of another.

- **Disclosure of Medical Information and Assignment of Benefits**: I authorize CBL to share my dental information and dental records to my insurance company and third party payers. I also assign the benefits payable for dental services to the dentist or organization furnishing the services or authorize such dentist or organization to submit a claim to Medicare or Medicaid for payment.

- **Patient/Family Conduct**: While in any CBL office, I agree to be respectful and courteous to the CBL staff, all dental providers and the other patients. I realize the importance of honoring my scheduled appointments and agree to provide at least 24 hours notice for rescheduling appointments. Failure to keep appointments or rescheduling without adequate notice will result in a $26 charge on my account. Repeated cancellations and/or no-shows will result in dismissal from the practice.

- **Notice of Privacy Practices**: I am aware of and/or have received CBL's Notice of Privacy Practices form. Upon receiving an inquiry as to the presence or condition of the patient, CBL may (unless otherwise requested by the patient, next of kin, or physician) release at its discretion: the name, address, age, sex, nature of injuries, and/or general condition of the patient. I understand that a separate written consent is required for me and/or the person(s) listed below to receive copies of my written dental records.

- **Consent:** I hereby consent to treatment by CBL and/or its employees and accept responsibility for payment of fees for such dental services. I understand that treatment may include a range of dental services as deemed necessary and appropriate by CBL.

- **This office is under video surveillance**.

However, I hereby give permission to my dentist and office personnel to verbally discuss any and all of my dental condition(s) with the following person(s).

_____ _____

Print Individual Name and Phone # Print Individual Name and Phone #

_____ _____

Print Individual Name and Phone # Print Individual Name and Phone #

By signing below, I, acknowledge that I have read and fully understand the meaning and consequences of each and every term and provision of this agreement.

_____ _____

Patient Name(s) Date

_____

Signature of Patient/Guardian