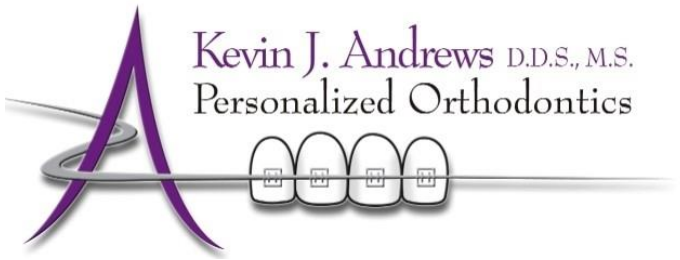

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
2. Obtaining payment from third party payers (e.g. my insurance company);
3. The day-to-day healthcare operation of the practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operation, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that as a courtesy to our patients that the practice provides an appointment reminder system that telephones all patients and reminds them about their appointment date and time with out specifically stating what type of appointment. I understand that I have the right to choose whether I want to be reminded of my appointment date and time by initialing the appropriate box.

Please initial whether you accept or decline:

_____ **Yes** - I am authorizing the use of the automated system to remind me of the appointment date and time.

_____ **No** - I do not authorize you to phone and remind me of the appointment date or time.

I understand that as a courtesy to our patients at times a reminder postcard might by mailed to my home if an appointment is needed. I understand that I can choose whether I want to receive reminders via our mail system or not by initialing the appropriate box.

_____ **Yes** – I am authorizing the use of email or text to remind me to phone the office to schedule an appointment.

_____ **No** – I do not authorize you to mail me any type of postcards even for the use of reminding me to phone you to schedule an appointment.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this date:_____, 20_____.

Please print – Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: **Kevin J. Andrews, D.D.S., M.S.**
Address: 2125 Green Vista Drive, Suite #104
City/State/Zip: Sparks, NV 89431