ALLEN B. BERMAN, D.D.S.
MICHAEL E. BERMAN, D.D.S.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I acknowledge that Allen B. Berman and Michael E. Berman's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Allen B. Berman and Michael E. Berman's Notice of Privacy Practices. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills and in the performance of health care operations of Allen B. Berman, D.D.S. and Michael E. Berman, D.D.S. This notice also describes my rights and the duties of Allen B. Berman, D.D.S. and Michael E. Berman, D.D.S. with respect to my protected health information.

The Notice of Privacy Practices for Allen B. Berman, D.D.S and Michael E. Berman, D.D.S. is also provided for review in the office waiting area. Allen B. Berman, D.D.S. and Michael E. Berman, D.D.S. also reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or ask for one at the time of my next appointment.

I have the right to revoke this consent, in writing, and understand that revoking my consent will not affect any action you took in reliance on my consent before you received this written notice. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

PATIENT ACKNOWLEDGMENT

By signing my name below, I acknowledge receipt of a copy of this notice and my understanding and agreement to its terms.

Signature of Patient or Personal Representative _____

Print Name of Patient _____

Date _____ Representative's Authority/Relationship _____