DOCUMENTATION OF RECEIPT

I, ____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

____________________________________ ___________________ __________
Signature of Patient/Patient Representative Relationship to Patient Date

AUTHORIZATION TO USE PHOTOGRAPHS AND NAMES IN OFFICE, PROMOTIONAL AND EDUCATION DISPLAYS

Due to the physical layout, nature, and "personality" of our office, we often display our patient's names and photographs on office bulletin boards, monitors, and our website. We are proud of our patient's accomplishments and display their photographs and/or names for good tooth brushing, good grades and other areas where we want to encourage and reward great patient performance. We also display photographs and names of our patients when they get their braces on and off, as well as those of our contest winners. The doctor also uses our own patient's photographs as examples in studies and educational presentations to dental offices and promotions to other groups.

We are very much aware of the importance of confidentiality of medical records. However, over the past 15 years, we have seen how much our patients and parents enjoy seeing what is happening with the rest of our orthodontic family. As always, you can trust our good judgment to provide a safe, fun, and healthy environment for orthodontic treatment. If you have any questions regarding this please don't hesitate to ask. We appreciate your confidence in us!

I give permission for the office Steven W. Smith, D.D.S., M.S. to use my/my child's name and photographs to be used as described above.

____ ________________
Signature Date

AUTHORIZATION TO SECURE CREDIT REPORTS

In most cases, we may provide "in house", no interest financing of orthodontic treatment. For us to do this for you, we must first run your credit report. This will be done prior to the time that fee arrangements are discussed. If you will be paying for orthodontic treatment in full prior to the start of treatment, we do not need to run this report.

I give permission for Steven W. Smith, D.D.S., M.S. to "run" my credit report for the purpose of determining financing for orthodontic treatment.

____ ________________
Signature Date

*******Please see other signature page********

PATIENT NAME: ____

CONSENT TO UNDERGO ORTHODONTIC TREATMENT

I hereby consent to the making of diagnostic records (including x-rays, before, during, and following orthodontic treatment) and to Dr. Smith providing orthodontic treatment described by him for the above individual.

____ ___________

Signature / Patient, Parent or Guardian Date

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize Dr. Smith to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate by Dr. Smith. I understand that once released, the above doctor has no responsibility for any further release by the individual receiving this information.

____ ___________

Signature / Patient, Parent or Guardian Date