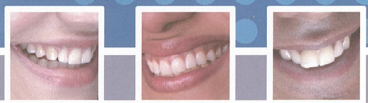
Arthur Glosman, DDS
450 N. Roxbury Dr.
Suite 222
Beverly Hills CA 90210
(310)273-2215
arthur@arthurglosmandds.com
www.arthurglosmandds.com



Informed Consent and Office Policy

I consent to the use of my dental records (e.g., x-rays, photographs and plaster models) for purposes of consultations, educational and research purposes, publication in professional journals, or in use in professional collateral materials, but not the use of my specific name, address, social security number, or other information which would have the effect of specially identifying me as an individual.

Cancellation and Broken Appointment Policy

Appointments are scheduled exclusively for our patients. This time is reserved especially for you. Therefore, on the day of your appointment, we expect you to arrive on time. If you cannot make the appointment, we require 48 hour notice so that we may offer this time to another patient.

Since this valuable time is reserved for you, understand that there will be a $120 charge for ALL missed/cancelled appointments without the required 48 hours notice. If you have a Monday appointment, please call the office the Friday before to avoid the fee.

HIPAA Acknowledgement

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
Health Insurance Portability Accountability Act (HIPAA), 1996

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:Dr. Arthur Glosman, 450 North Roxbury Drive, Suite 222, Beverly Hills, CA 90210, 310.273.2215.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE
By signing below, I state that I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.