Great Expressions® DENTAL CENTERS

Patient Registration Form

Patient Last Name: _____ **First:** _____ **Initial:** _____

How do you wish to be addressed? _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Telephone *(Home):* _____ *(Work):* _____ *(Mobile):* _____

Email: _____ Social Security Number: _____

Insurance Information

Primary Insurance	**Secondary Insurance**
Subscriber Name:	Subscriber Name:
Subscriber ID:	Subscriber ID:
Date of Birth:	Date of Birth:
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name:	Employer Name:
Employer Phone:	Employer Phone:
Insurance Company:	Insurance Company:
Insurance Group:	Insurance Group:
Insurance Phone:	Insurance Phone:

Please present your insurance card to be photocopied for our records.

Responsible Party *(If minor)*

Last Name: _____ First: _____ Initial: _____

Address *(If different):* _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Telephone *(Home):* _____ *(Work):* _____ *(Mobile):* _____

Email: _____

Emergency Contact

Last Name: _____ First: _____ Initial: _____

Telephone *(* ☐ *Mobile* ☐ *Work* ☐ *Home):* _____

Consent

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my *(or my child's)* health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I attest to the accuracy of the information on this page.

Signature: _____ Date: _____
(Responsible Party, if under 18)

Great Expressions®
DENTAL CENTERS

OFFICE USE ONLY
Patient #: _____
Last updated date: _____
Blood Pressure: _____

PLEASE COMPLETE ALL INFORMATION - THANK YOU

Last Name: _____ **First Name:** _____ **Middle Initial:** ____ **Date Of Birth:** _____

Dental History

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays: _____

Please check if you have/had:

- ☐ Bad breath
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Dry mouth
- ☐ Extra permanent teeth
- ☐ Food collection between teeth
- ☐ Grind teeth
- ☐ Clench teeth
- ☐ Growths or sore spots in your mouth
- ☐ Gums swollen, tender or bleeding
- ☐ Head, neck, TMJ/jaw pain, or aches
- ☐ Loose teeth or broken fillings
- ☐ Missing permanent teeth
- ☐ Mouth breathing
- ☐ Nitrous oxide
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ Sensitivity to pressure or irritants *(cold, heat, sweets)*
- ☐ Smokeless tobacco
- ☐ Do you currently smoke or have you smoked? Check applicable options below:
  - ☐ Occasionally/Light ☐ Average
  - ☐ Heavy ☐ Ex-Smoker
- ☐ Do you have a history or sleep apnea or snoring?
- ☐ Any injuries to face, mouth or teeth? If Yes, please explain: _____
- ☐ Have you ever had trouble from previous dental care? If Yes, please explain: _____
- ☐ Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? If Yes, please explain: _____
- ☐ How often do you floss? _____
- ☐ How often do you brush? _____
- ☐ Do you premedicate prior to dental treatment?

Additional questions for patients under 14:

- ☐ ADHD/ADD
- ☐ Immunizations are current
- ☐ Frequent bottle use/Sleeps with bottle at night
- ☐ Frequent sores on lips or mouth
- ☐ Nail biting
- ☐ Thumb, finger, or lip sucking or biting habit(s)
- ☐ Local anesthetic has been administered previously
- ☐ Reached puberty

Medical History

Physician's name _____ Physician's phone # _____ Date of last visit _____

Please check if you have/had:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial joints
- ☐ Birth control
- ☐ Blood disease
- ☐ Bone disorders
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Clotting disorders, and/or prolonged bleeding
- ☐ Cortisone treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Endocrine problems
- ☐ Epilepsy/Seizures
- ☐ Fainting or vertigo
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Heart, artificial valves
- ☐ Heart, mitral valve prolapse
- ☐ Hepatitis *(select type from below)*
  - ☐ A ☐ B ☐ C
- ☐ Herpes
- ☐ High blood pressure
- ☐ Immune deficiency *(including HIV/AIDS)*
- ☐ Jaundice/Other liver problem
- ☐ Kidney disease
- ☐ Low blood pressure
- ☐ Nursing
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Pregnant, due date: _____
- ☐ Radiation treatments
- ☐ Respiratory disease
- ☐ Rheumatic fever/disease
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Sleep study/CPAP
- ☐ Sickle cell anemia
- ☐ Skin rash
- ☐ STD/STI
- ☐ Stroke
- ☐ Swelling of feet/ankles/joints
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tonsils removed? Date: _____
- ☐ Tuberculosis *(TB)*
- ☐ Tumor or growth on head/neck
- ☐ Ulcer
- ☐ Weight loss, unexplained
- ☐ Have you had any blood transfusions? Approximate dates: _____
- ☐ Do you consume alcoholic beverages?
- ☐ Are you currently under the care of a Physician?
- ☐ Do you have a history of substance abuse?
- ☐ Have you ever had surgery? Approximate date of last surgery: _____
- ☐ Are you allergic or sensitive to latex?
- ☐ Do you have any allergies? *(Select one or more)*:
  - ☐ Hay fever, sinusitis
  - ☐ Nickel
  - ☐ Nuts
  - ☐ Other, please specify: _____
- ☐ Do you have Asthma?
  - ☐ Required hospitalization
  - ☐ Used steroids
  - ☐ Date of last episode: _____
- ☐ Are you currently taking any medications? If yes, please list: _____
- ☐ Any other medical conditions or concerns? _____

MedHX Notes (OFFICE USE ONLY)

Authorization and Release

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____

DENTAL & MEDICAL HEALTH HISTORY

MEDICAL HEALTH HISTORY – UPDATE AND EXCEPTIONS

I have read my medical history and confirm that it adequately states past and present conditions

DATE	EXCEPTIONS	BLOOD PRESSURE	PATIENT INITIALS	REVIEWED BY (INITIALS)

Great Expressions® DENTAL CENTERS

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Ask us to correct your medical record
- Request confidential communication
- Ask us to limit the information we share under certain circumstances
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you as your personal representative (medical power of attorney)
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Provide you with appointment reminders (such as voicemail messages, texts, postcards, or letters).

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information found on Page 2.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, 1-800-368-1019, TDD: 1-800-537-7697, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information in the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or maintain psychotherapy notes at this practice.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Organizations
This Notice of Privacy applies to all affiliated entities doing business as Great Expressions Dental Centers.

Contact: Privacy Officer
Great Expressions Dental Centers
29777 Telegraph Rd., Suite 3000
Southfield, MI 48034
Phone: 888-SMILE-80 (888-764-5380)
Website: www.GreatExpressions.com
Email: privacyofficer@greatexpressions.com

Effective Date of this Notice: February 19, 2016 *(Last Updated: 01/16/2020, 08/01/2022)*

Great Expressions DENTAL CENTERS

HIPAA Privacy Practices Acknowledgment

Section A: Patient Information

Patient Name:

Patient Phone Number:

Section B: Acknowledgment Of Receipt Of HIPAA Notice Of Privacy Practices

Notice of Privacy Practices: 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 Acknowledgment. We encourage you to read our Notice carefully and completely before signing this Acknowledgment.

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 an additional copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer: Privacy Officer, Great Expressions Dental Centers
Telephone: 888-SMILE-80 (888-764-5380)
Email: privacyofficer@greatexpressions.com
Address: 29777 Telegraph Road, Suite 3000, Southfield, MI 48034

Section C: Signature

I, _____ have had full opportunity to read and consider the contents of this Acknowledgment and the Notice of Privacy Practices. I understand that, by signing this Acknowledgment, I am giving my authorization to your use and disclosure of my protected health information in accordance with the Notice.

Signature: Date:

If this Acknowledgment is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: Relationship to Patient:

Section D: For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign _____ (initials of GEDC employee)
- ☐ Communication barriers prohibited obtaining the acknowledgment _____ (initials of GEDC employee)
- ☐ An emergency situation prevented us from obtaining acknowledgment _____ (initials of GEDC employee)
- ☐ Other *(please specify):* _____ _____ (initials of GEDC employee)

Signature: Date:

You are entitled to a copy of this acknowledgment after you sign it.

Great Expressions® DENTAL CENTERS

HIPAA Authorization

HIPAA Authorization for Uses and Disclosures of Protected Health Information

Authorization of Uses and Disclosures.
I hereby authorize and direct Great Expressions Dental Centers as well as their associated dentists, providers, employees, office staff, and agents including affiliated health care practitioners (collectively "GEDC") to use and disclose my "protected health information" ("Information"), as described below.

Description of Information.
I understand that my Information includes, but is not limited to, my name, date of birth, and other personal information and identifiers (including my address), medical and dental information, including information about my health condition and related medical conditions, medical and dental records, and financial information (including information about my insurance) as well as other personal information collected by GEDC about me or otherwise provided by me to GEDC.

Purposes.
I authorize and direct GEDC to use my Information, and to disclose my Information for the following purposes:

a. **For marketing communications.** For example – GEDC may contact me about new products, services, or events that it thinks may be of interest to me. GEDC may also contact me for the purposes of fundraising, publicity and advertising for broadcast in print or other media including on the internet. Note that GEDC may receive remuneration, either directly or indirectly, in exchange for making these marketing communications.

b. **For purposes related to treatment, payment (e.g., to a parent, other family member or personal representative who may assist in coordination of my care) and/or GEDC health care operations, with the following individuals:**

Name: _____

Relationship: _____

Phone Number: _____

Treatment not Conditioned; Signing is Voluntary.
I understand that GEDC will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization and will still be able to receive treatment. In addition, if I refuse to sign this Authorization GEDC is still permitted to make uses and disclosures of my Information for treatment (e.g., to other health care providers), payment (e.g., to my insurance company), and health care operations (e.g., for internal audits), as permitted by law.

Expiration.
Unless revoked, this Authorization will expire ten (10) years from the date signed below.

Revocation.
I understand that I have the right to revoke this Authorization by providing written notice of my desire to revoke to **Privacy Officer, 29777 Telegraph Road, Suite 3000, Southfield, MI 48034**, or via email at privacyofficer@greatexpressions.com,however, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this Authorization.

Potential for Redisclosure.
I understand that Information disclosed pursuant to this Authorization may be redisclosed by GEDC and may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA"), a federal privacy law.

Copy.
I understand that I will be provided with a copy of this signed Authorization.

I hereby certify that I am over the age of 18 and I have read the foregoing and fully understand the contents.

Name *(please print):* _____

Patient Signature: _____ Date: _____

Date of Birth: _____ Age: _____

Parent/Guardian/Personal Representative Signature (required if subject is under 18 years of age)

Description of Relationship to Patient: _____

For Office Use Only
We attempted to obtain a written authorization for the use and disclosure of protected health information, but authorization was refused.

Signature: _____ Date: _____

Great Expressions® DENTAL CENTERS

Financial Policy

Patient Name: _____ **Date:** _____

Great Expressions Dental Centers and affiliated companies, collectively known as "GEDC", are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- **GEDC PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

Adult Patients
Adult patients are responsible for full payment at time of service.

Minors Accompanied By An Adult
The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

Unaccompanied Minors
The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

Insurance

GEDC provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by GEDC staff regarding his/her remaining benefit in any such benefit period

The claims we submit to insurance companies indicate that you have assigned those benefits to GEDC. However, if you are paid by the insurance company instead of GEDC, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

Medicare/ Medicaid/ Champus/ Worker's Compensation
If you are covered by Medicare, Medicaid, Champus, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the GEDC office on the date of service.

Delinquent Payments
It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

Missed Appointments
Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $35.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: _____ **Date:** _____

White Copy - Patient YellowCopy - Office/Chart

Great Expressions® DENTAL CENTERS

Communication Policy

Opt-In for Email and Text Communications

You may opt-in to receiving emails and texts as described below. In either circumstance, Great Expressions will never ask for credit card numbers via email or text message. If you think you may have received a suspicious email or text from Great Expressions, please contact our corporate office immediately at 888-SMILE-80 (888-764-5380).

Email Appointment Confirmations
By opting in to email appointment confirmations, you will receive reminders of upcoming appointments, and reminders to schedule appointments.

Text Appointment Confirmations
By opting in to text appointment confirmations, you are authorizing GEDC to send text message appointment reminders to you on your provided cell phone number. You understand that you may reply with various commands to receive account information such as balances, future appointments, office location and other alerts as described in our Text Message System command list located on the text appointment confirmations page.

You also agree that all individuals associated with your account may receive alerts referencing the account guarantor and/or dependents. Text message charges from your cell phone provider may apply.

Your enrollment indicates that your represent and warrant that you are the person legally responsible for all use of the accounts, are at least 18 years of age, and agree to all terms and conditions of use for the text messaging services.

Great Expressions Dental Centers offers a text messaging system to current patients to receive appointment confirmations, account balance information, and other services and content deemed appropriate. By opting-in to our text message system (via mobile opt-in or automated opt-in), you are providing consent to use personal information to provide the services available by Great Expressions Dental Centers, including customized content. Message and data rates may apply; please contact your wireless provider for specific information regarding your text messaging usage and charges.

The text messaging system is provided by Great Expressions Dental Centers to our patients on an as-is basis. Data obtained from you in connection with the text message system may include, but not be limited to, your name, address, cell phone number, dental office and location, future appointment dates and times, and account information. Great Expressions is not liable for any delays that may be experienced during the transmission of any messages, as delivery is based on the speed and effectiveness of your wireless provider.

Opt-In and Opt-Out Text Policy
You may opt-out of our text message system by sending “STOP” or “UNSUBSCRIBE” to 98269 or 200100. You will no longer receive appointment confirmations or other account information via text message if you opt-out of this service.

How to Opt-In: Text SUBSCRIBE to 98269 or 200100* to receive text message confirmation and account alerts. You will be sent a message informing you of applicable message and data rates for all subsequent text messages.

Great Expressions also provides automated opt-in to text message reminders when a valid cell phone number is provided during the patient registration and/or check-in process.

**Great Expressions Dental Centers Text Message System. Message and data rates may apply. By participating, you consent to receive text messages sent by an automatic telephone dialing system. Messages per month vary based on appointments scheduled. Consent to these terms is not a condition of purchase.*

For Help or Support: If you need assistance with your text message appointment confirmations or account alerts, please read the Frequently Asked Questions. If your question is not answered, you may contact us here, or simply reply with the word “**HELP**” to the message you received for assistance.

GEDC may terminate this agreement and any related services, with or without cause, at any time. All services are provided on an “as is” and “as available” basis without warranties of any kind, either express or implied, including, but not limited to, warranties of merchantability, fitness for a particular purpose or non-infringement. GEDC expressly disclaims any representation or warranty that the services will be error-free, timely, secure or uninterrupted. No oral advice or written information given by GEDC, its employees, licensors or agents will create a warranty, nor may you rely on any such information or advice. Under no circumstances will GEDC or its affiliates be liable for any direct, indirect, incidental, special or consequential damages that result from the use of or inability to use the services, including but not limited to reliance on any information obtained from the services, or that result from mistakes, omissions, interruptions, deletion of files, text, or e-mail; loss of or damage to data, errors, defects, viruses, delays in operation or transmission, or any failure of performance, whether or not limited to acts of god, communication failure, theft, destruction or unauthorized access to records, programs or services. GEDC reserves the right to modify the terms and conditions of use at any time and without advance notice, and any changes shall be effective upon making the modified provisions available on GEDC’s website, and continued use of the services after any such changes shall constitute your consent to such changes. GEDC does not and will not assume any obligation to notify you of any changes to the terms and conditions of use. By signing up for this service, you agree that your sole and exclusive remedy to any issues arising from or relating to the services is to discontinue using the services. The terms of this section shall survive termination or revocation of the Patient Communication Consent Form and/or use of the services.

Supported Carriers: AT&T, Sprint, Nextel, Boost, Verizon Wireless, U.S. Cellular®, T-Mobile®, Cellular One Dobson, Cincinnati Bell, Alltel, Virgin Mobile USA, Cellular South, Unicel, Centennial and Ntelos

For help or information on this program send “**HELP**” to 200100. To cancel your plan, send “STOP” to 98269 or 200100 at any time. For additional assistance, contact customer service at 888-SMILE-80 (888-764-5380) or access support within GreatExpressions.com/patient-center/confirm/text/. Msg Freq based on acct settings.

I consent to receiving electronic communications, including email and text messages regarding treatment, payment and health care operations in accordance with this document.

Signature: _____ **Date:** _____