PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE			
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NUMBER			
EMAIL			
DATE OF BIRTH	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NUMBER			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NUMBER			
DATE OF BIRTH	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NUMBER			
IF YOUR CHILD'S NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO			

DENTAL INSURANCE

PRIMARY CARRIER	
INSURANCE COMPANY	
INSURANCE PLAN NAME	
EMPLOYER	
PRIMARY INSURED	
GROUP PLAN	
GROUP NO.	
DATE OF BIRTH	DATE EMPLOYED
SUBSCRIBER ID NO.	
EMPLOYEE SOCIAL SECURITY NO.	

SECONDARY CARRIER	
INSURANCE COMPANY	
INSURANCE PLAN NAME	
EMPLOYER	
PRIMARY INSURED	
GROUP PLAN	
GROUP NO.	
DATE OF BIRTH	DATE EMPLOYED
SUBSCRIBER ID NO.	
EMPLOYEE SOCIAL SECURITY NO.	

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
RELATIONSHIP TO PATIENT	
ADDRESS	
CITY	
PHONE NUMBER	
YOU	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NUMBER	
YOUR SPOUSE	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NUMBER	

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP
REFERRED TO US BY	
YOUR FORMER ADDRESS	
CITY	STATE
EMERGENCY CONTACT	
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY	STATE

APPOINTMENT REMINDERS

WE EMAIL AND SMS (TEXT) TO REMIND YOU OF YOUR APPOINTMENT	
EMAIL (ALTERNATE, IF DESIRED)	
MOBILE	Check here to opt-out of email/text reminders ☐

Patient Name	Dental History
Patient Account No.	Medical Alert

WELCOME! *So that we may provide you with the best possible care please complete both sides of this medical/dental history form.*
All information is completely confidential.

What is the reason for your visit today?_____

_____

Date of Last Dental Visit_____ Last Dental Cleaning_____ Last Full Mouth X-rays_____

What was done at your last dental visit?_____

Previous Dentist's Name_____

Address_____ State_____ Zip_____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth?_____ How often do you floss?_____

What other dental aids do you use? (Interplak, toothpick, etc.)_____

Do you have any dental problems now? Yes No
If yes, please describe:_____

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum diseases or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth (pencils, pipes, pins, nails, fingernails)?	Yes	No
Mouth breathe while awake or sleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause _____		
_____		

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of face)?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with you teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern? _____		
_____		
Have you ever had an upsetting dental experience?	Yes	No
If so, please describe _____		
_____		

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe _____

_____

(Please complete other side)

Patient Name	Medical History
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, for what?
   Physician's Name_____ Phone_____

   Address_____ City_____ State_____ Zip_____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medication, drugs or pills now? Yes No
   If yes, please list name and dosage_____

   _____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No
   If yes, please list:
5. Have you been a patient in the hospital during the past five years? Yes No
6. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No	Hepatitis A (infectious) B (serum)	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
High Blood Pressure	Yes No	Contact Lenses	Yes No	Cold Sores/Fever Blisters	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Yellow Jaundice	Yes No
Swollen Ankles	Yes No	Allergies or Hives	Yes No	Neurological Disorders	Yes No
Stroke	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Diet (Special/Restricted)	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	Chemotherapy	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Psychiatric/Psychological Care	Yes No

7. Do you use more than two pillows to sleep? Yes No
8. Have you lost or gained more than 10 pounds in the past year? Yes No
9. Do you have or have you had any disease, condition, or problem not listed? Yes No
10. If yes, please list:
11. **Women**: Are you: **Pregnant?** Yes ____Months No **Nursing?** Yes No
    Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

*Patient/Guardian Signature*_____ *Date*_____

History Review

Doctor Signature_____ Date_____

Mark Peppard, DDS, MAGD

4005 Spicewood Springs Rd., Bldg. C, Suite 500

Austin, TX 78759

512-835-9557 www.pepdds.com

Email: Office@pepdds.com

IMPORTANT INSURANCE INFORMATION YOU NEED TO KNOW

Dental Insurance History:

During the past few decades, dental insurance plans have become an integral part of healthcare planning for families. Unfortunately, while the cost of dentistry and dental insurance has risen, **Insurance companies have not significantly increased dental benefits in the past 2-3 decades.**

The type of treatment and care you need and receive from Dr. Peppard is based upon years of professional expertise, judgment and a philosophy of extensive patient education and consultation; NOT on whether you are covered by a dental plan. In recent years, many insurance companies have tried to control benefits they payout by having healthcare providers sign contracts making the Dentist an "in-network" provider. In some cases, the Dentist may be an actual employee of a "dental service organization/corporation" (DSO). As a consequence, treatment may be directly or indirectly influenced by the contract limitations, and Contracted Healthcare Providers are limited in what type/level of services they deliver to their patients, which may lead to ethical dilemmas.

Where We Stand:

At this practice, our mission is to provide each patient with the highest quality of care available. We utilize the most updated techniques and the most evidence based dental materials when providing care for our patients. We are committed to staying on the leading edge of knowledge as it relates to Dentistry.

My goal is to provide you the privilege of making educated, considered decisions for your healthcare. The benefit of knowledge will help you with understanding the many options the Art and Science of Dentistry provides vs. being a victim of Insurance Contract Limitations.

How Insurance Companies Pay Benefits:

Many patients wonder why their dental plan sometimes pays different amounts than were indicated in the policy provisions of their insurance carrier. These differences occur because contractual reimbursement levels are based on actuarial tables developed by insurance companies and categories of covered procedures are limited by the contractual language of the policy. The actuarial tables used by the insurance companies are not reflective of usual and customary fees. For this reason, you may receive a lower percentage of the reimbursement level for a fee than indicated in your dental plan. For example, if your plan states that it will pay 80% of the fee for a procedure, it means 80% of the fee arbitrarily determined by the insurance company, and not the actual fee charged by the dental offices in different areas.

Dr. Peppard's Philosophy:

Dental Insurance plans try to control their costs by not only **limiting the fee** they cover for a specific code/procedure, but also by simply **not covering procedures the insurance company determines as not necessary.**

Dr. Peppard will not compromise his expertise or ethics in treating you or your family, and he will not be limited by what the insurance company tries to dictate. **AN INSURANCE COMPANY IS NOT YOUR DOCTOR.**

AVAILABLE TO YOU, THE INSURANCE COMPANY'S CLIENT/CUSTOMER, IS A "PLAN DOCUMENT", WHICH WILL DETAIL COMPLETELY THE SPECIFICS OF YOUR COVERAGE. THIS "PLAN DOCUMENT" IS NOT AVAILABLE TO THE DOCTOR!

If, after reading this, you believe the dental benefits provided by your plan are inadequate, you may want to discuss the matter with your employer, union or association. Appropriate alternatives can be investigated. Your company's Human Resources Department should provide you with a statement of benefits or website link to help in your responsibility to know your plan. You are the Customer of the insurance company, not the Doctor.

Mark Peppard, DDS, MAGD

4005 Spicewood Springs Rd., Bldg. C, Suite 500

Austin, TX 78759

512-835-9557 www.pepdds.com

Email: Office@pepdds.com

Consent and Acknowledgement

I _____, in the presence of my Dentist or dental practice privacy official, agree that the practice may electronically communicate with me at the following email or mobile number:

Email_____

Mobile phone number_____

Patient's Date of Birth (for verification purposes)_____

I acknowledge that the practice may send the following by email or text:

(Check each that apply, and then provide your initials at the end of each item selected)

___Information about my Account _____(Initials)

___Information about a specific dental visit _____(Initials)

Acknowledgement

You must acknowledge each of the following before we send communications electronically; Please initial below:

___All electronic communications from our practice

___I am responsible for providing the dental practice any updates to my email or mobile phone number

___I am able to receive information electronically and store it securely away from a public computer

___I am able to receive text messages

___I can withdraw my consent to electronic communications by calling 512-835-9557

Please be aware, if you withdraw consent, there will be NO electronic communication of appointments and it becomes YOUR responsibility to remember your appointments. You will be charged for a missed appointment with less than 24 hours notice.

Patient's Signature_____ Date_____

Parent or Responsible Party _____Date_____

(For Minor children)

Mark Peppard, DDS, MAGD

4005 Spicewood Springs Rd., Bldg. C, Suite 500

Austin, TX 78759

512-835-9557 www.pepdds.com

Email: Office@pepdds.com

Dental Procedures General Consent

____I agree to disclose all previous illnesses, medications being taken, allergies and medical history. I also agree to disclose all changes in my medical history since my last visit.

____ I also agree I will update any changes in my medical history at any visit in the future. Undisclosed medical history is a risk factor.

____I understand antibiotics and other medications can cause allergic reactions which can be life threatening. Some antibiotics interfere with the effectiveness of birth control pills and daily vitamins. Latex allergy may cause rashes. Epinephrine may increase heart rate, and depending on my health, can be dangerous to me.

____Fillings and crowns require removal of diseased and normal tooth structure in order to be properly completed. A percentage of these teeth will experience post procedure infection or hyper sensitivity resulting in the need for a root canal. The ability to predict the need for a root canal cannot be guaranteed.

____Root canal treatment can fail and may require additional treatment or end with the tooth being extracted.

____Porcelain crowns, metal crowns, veneers, composite fillings or cosmetic bonding are all manmade materials and cannot be expected to last for life in the oral environment. Dr. Peppard will endeavor to utilize the best materials, the best techniques with the best training for your benefit, but if material failure occurs, I will be responsible for the cost of repair or replacement.

____The color of porcelain crowns, veneers, and bondings cannot be changed or bleached after they are placed.

____If I smoke, fail to floss, neglect to maintain routine dental exams and cleanings as recommended during the course of the year, I understand I can expect to have a deteriorating oral health, which will require treatment.

____I understand all extractions of impacted and erupted teeth and surgeries carry risks which can include dry sockets, post-surgical infections, and allergic reactions. Some post-operative complications can be life threatening.

____I understand local anesthesia has risks that include but are not limited to the following: dizziness, nausea, accelerated heart rate, slower heart rate, allergic reactions, restricted mouth opening, and muscle soreness at the injection site. Prolonged numbness and tingling of the tongue, chin, lips and cheeks may persist for days, weeks, months or be permanent.

____I understand I may need treatment beyond what was originally planned for which I will be financially responsible. There may be times when the additional treatment requires additional care by a specialist. I will be financially responsible for that specialist's care.

____I understand there are services and charges beyond what my insurance will pay, for which I am financially responsible.

____We DO guarantee treatment up to three years if you are coming for your regularly scheduled Hygiene visits, exams, cleanings and your periodic necessary diagnostic x-rays. Failure on your part to be responsible for your oral health will negate my guarantee.

____I acknowledge I have read the above, discussed all questions and concerns I might have regarding dental treatment. I am satisfied with the information provided to me above, and I consent to treatment.

Specific procedure consents will be required at time of treatment.

_____ _____ _____

Signature of Patient or Parent/Guardian of Minor **Date** **Reviewed By**

Mark Peppard, DDS, MAGD

4005 Spicewood Springs Rd., Bldg. C, Suite 500

Austin, TX 78759

512-835-9557 www.pepdds.com

Email: Office@pepdds.com

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM

The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy carefully and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of Mark Peppard, DDS. I understand that the organization reserves the right to change their notice and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____

Name of Patient

_____

Signature of Patient (or Parent/ Responsible Party's Signature for Minors)

_____

Date

Mark Peppard, DDS, MAGD

4005 Spicewood Springs Rd., Bldg. C, Suite 500
Austin, TX 78759
512-835-9557 www.pepdds.com
Email: office@pepdds.com

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty:

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect 01/01/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in the privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change the Notice and provide the Notice at our practice location, and we will distribute it upon request.

You may get a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of the Notice, please contact us using the information listed at the end of this Notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information:

We use and disclose health information about you without authorization for the following purposes:

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our health care operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To you or your Personal Representative: We may use or disclose health information to you, as described in the Patient Rights section of the Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or capacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will NOT use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required to lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody, the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters.)

Patient Rights:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $5.00 for each page, $25.00 per hour for the staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us by using the information listed at the end of this Notice for a full explanation of the fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before 01/01/2013. If you request this accounting more than once in a 12 month period, we may charge you a reasonable fee, cost-based for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases, we are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we amend your health information. Your request must be done in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our website or by electronic mail (email).

Questions and Complaints: If you want more information about our privacy practices or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or the disclosure of your health information or to have us communicate with you by alternative means, you may complain to us by using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file a complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Janie Peppard

Telephone: 512-835-9557; FAX: 512-836-6414
Email: office@pepdds.com
4005 Spicewood Springs Rd., C-500, Austin, TX 78759

Mark Peppard, DDS, MAGD

4005 Spicewood Springs Rd., Bldg. C, Suite 500

Austin, TX 78759

512-835-9557 www.pepdds.com

Email: Office@pepdds.com

INFORMED CONSENT FOR DATA

____I understand that photographs, x-rays, and other records may be made during the course of my examination, treatment, and follow-up care, for diagnosis and treatment planning. I give my permission for such items to be used for purpose of research, education or publication in professional journals. Patient identity will not be revealed without written permission.

____I understand that I may revoke this authorization at any time by notifying Dr. Peppard in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and authorized staff will have access to them. They will be kept as long as legally relevent and after that time destroyed or archived.

____Images/Data to be emailed to the patient or another professional involved in your healthcare may be sent via email that is not encrypted. There is some risk, the protected health information could be read or accessed by a third party while in transit.

I, _____ give permission for Dr. Peppard or his authorized staff to transmit my healthcare information via an unencrypted email.

Patient Signature _____ Date_____

Witness_____