Anthony J. Hornaday, D.D.S.
Oral and Maxillofacial Surgery of East Central Indiana
620 S. Tillotson Avenue ◆Muncie, IN 47304 ◆(765) 289-9705

Office Financial Policy

1. If the patient does not have insurance, full payment is required at the time of surgery.

2. If you are having a single tooth removed, the entire fee (which we will provide you with prior to your services) will be due the day of the extraction. We will file your insurance claim for you and will reimburse you if any payment is made by your insurance company.

3. If the patient does have insurance, we do require a percentage of the total fee to be paid at the time services are rendered which is an ESTIMATE of your out of pocket expense. There may be an additional amount due after your insurance pays.

4. We are not responsible for benefits quoted to us by your insurance company whether this was received over the phone or if we have received a written predetermination on your behalf. Insurance companies will not guarantee coverage and/or payment to us until they receive an actual claim; therefore, regardless of the information that was given to us by your insurance company, either verbally or in writing, you may still be responsible for the entire fee for your treatment charged by this office.

5. We will file claims to all insurance companies, however, the ONLY insurance companies that Dr. Hornaday is contracted with are Guardian, Delta Dental Premier dental insurance and Medicaid. Regardless of insurance coverage, the patient, or patient's legal guardian, is ultimately responsible for all fees charged by this office.

6. Sixty days will be allowed for your insurance company to process and pay your claim. If, after sixty days, no notice has been received from your insurance company, it is your responsibility to contact them directly and the entire balance is your responsibility at that time.

7. If your insurance requires a predetermination prior to the procedure, it is the patient's (or patient's legal guardian's/Power of Attorney's) responsibility to notify our office.

8. The parent (or legal guardian) that accompanies a minor to the office will be responsible for all fees charged. We cannot and will not contact someone who was not present in our office to ask for payment, such as in a divorce situation.

9. Should your account become past due, you will be responsible to pay all collection costs, including collection agency fees, attorney fees, and all court costs. These fees will be added to your balance and this new amount will be placed with our collection agency and become your responsibility to pay.

10. Please note that if any portion of your care is rendered at IU Health Ball Memorial Hospital (in-patient or out-patient), there will be separate charges from the hospital that may or may not be fully covered by your insurance. Dr. Hornaday is not financially affiliated with the hospital and is not responsible for and has no knowledge of these charges. It is your responsibility to check with your insurance to see what will or will not be covered.

11. This signature is on file as my authorization for the release of information necessary to process my claim and collect monies owed. I hereby authorize payment directly to Dr. Anthony Hornaday of the insurance benefits otherwise due me. I certify that I am the legal guardian and/or power of attorney of the patient listed on this form. I have read the above financial policy and agree to all of the terms therein.

Patient_____ Patient's Signature _____Date _____

Parent or Legal Guardian Signature _____Date _____

Witnessed By _____Date _____

Patient Information

Anthony J. Hornaday, D.D.S.
Oral and Maxillofacial Surgery

Dr. Mr. Mrs. Ms. Miss _____
First Middle Last Nickname

Address: _____ City/State: _____ Zip: _____

Home Tel #: _____ Work Tel #: _____ Cell #: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: Male Female Marital Status: Single Married Widowed Divorced

Soc Sec. #: _____ Pharmacy:_____

Employer: _____ Occupation: _____

Patient's **Dentist**: _____ **Physician**: _____ **Orthodontist**: _____

Who referred you to our office? Dentist Physician Orthodontist Friend _____ Other_____

Have you or any member of your family been a patient in our office before? Yes No When? (Year): _____

Who?: _____ Relationship to patient: _____

If patient is a full-time student, name of school: _____

Emergency Contact: _____ Daytime phone #: _____

Relationship to patient: _____

Person **Responsible for Payment (if different from above)**

Person Responsible for Payment: _____

Address: _____ City/State: _____ Zip: _____

DOB: _____/_____/_____ Soc Sec #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I understand in signing this statement that I am financially responsible to Dr. Anthony J. Hornaday for all fees incurred and all costs of collection: including but not limited to service, collection, collection agency, and attorney fees.

If your insurance company does not pay your claim as expected, the responsible party is obligated for the balance of the account. I hereby authorize the insured's insurance company to pay directly to Dr. Anthony J. Hornaday any and all of the benefits otherwise payable to me or the patient.

Signature of Party Responsible for Payment: _____ Relationship to Patient: _____

Print Name: _____

DENTAL Insurance Coverage Information **(If you have additional coverage, please request an additional form)**

Primary Dental Insurance Name of Insurance Company**:** _____

Subscriber Name: _____ DOB: _____/_____/_____ Insured's Daytime Phone #: _____

Subscriber Address: _____Plan ID (If other than SS#): _____

Subscriber Soc Sec #: _____ Group #: _____ Employer Name: _____

Relationship to Patient: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____

MEDICAL Insurance Coverage Information **(If you have additional coverage, please request an additional form)**

Primary Medical Insurance Name of Insurance Company: _____

Subscriber Name: _____ DOB: _____/_____/_____ Insured's Daytime Phone #: _____

Subscriber Address: _____Plan ID (If other than SS#): _____

Subscriber Soc Sec #: _____ Group #: _____ Employer Name: _____

Relationship to Patient: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____

I certify all information is true, correct, and complete and authorize the release of health care information for the purpose of evaluating and administering claims for benefits. I authorize payment of medical/dental benefits to Dr. Hornaday and accept full financial responsibility regardless of insurance coverage. I also certify that I am the **legal guardian** of the patient listed on this form.

Signed: _____ _____ Date: _____
Patient or Legal Guardian Signature Relationship to Patient

Print Name: _____

Patient Information

Anthony J. Hornaday, D.D.S.
Oral and Maxillofacial Surgery

Patient Name: _____
First Middle Last Nickname

Reason for today's office visit: _____

Height: _____ **Weight**: _____ **Age**: _____	**Yes**	**No**	**Notes**
Have there been any changes in your general health in the past year?.....>	[ ]	[ ]	
Are you under the care of a physician?.....>	[ ]	[ ]	
For what? _____			
Have you ever been hospitalized or undergone any surgery?.....>	[ ]	[ ]	
Please explain: _____			

Please indicate if you have ever had any of the following conditions:

	Yes	No	Notes		Yes	No	Notes
Heart Disease				Anemia			
Chest Pain				Bleeding Problems			
Heart Attack				Sickle Cell Anemia			
Bypass				Stomach Ulcer			
Angioplasty				HIV or AIDS			
Heart Murmur				Cancer or Tumors			
Mitral Valve Prolapse				Radiation/Chemotherapy			
Rheumatic Fever				Liver Disease			
High Blood Pressure				Hepatitis or Jaundice			
Artificial Heart Valve				Diabetes			
Pacemaker				Thyroid Disease			
Stroke				Kidney Disease			
Glaucoma				Arthritis			
Asthma				Artificial Joints			
Lung Disease				Seizures (epilepsy)			
Tuberculosis				Illicit (Illegal) Drug Use			
Shortness of Breath				Alcohol/Drug Abuse			
Swollen Ankles				Psychiatric Disorder			

	Yes	**No**
• Are you currently taking any drugs or medications?.....>	[ ]	[ ]
Please List: _____		
_____		
• Have you ever had any adverse reaction to local or general anesthetic?.....>	[ ]	[ ]
• Are you allergic to anything?.....>	[ ]	[ ]
Please List: _____		
• Have you ever been treated or are you taking medicine for osteoporosis?.....>	[ ]	[ ]
• Have you ever been prescribed any bisphosphonate medications such as:		
Fosamax, Aredia, Zometa, Actonel, Boniva?.....>	[ ]	[ ]
• Is this visit a result of an accident?.....>	[ ]	[ ]
If yes, date of accident and describe: _____		
_____		
• Do you smoke?.....>	[ ]	[ ]
• Women: Are you pregnant?.....>	[ ]	[ ]
Are you nursing?.....>	[ ]	[ ]
Do you take birth control?.....>	[ ]	[ ]
• Do you have any other medical conditions not listed above?.....>	[ ]	[ ]
Please List:_____		
_____		

I certify all above information is true, correct, and complete and authorize the release of health care information for the purpose of evaluating and administering claims for benefits. I authorize payment of medical/dental benefits to Dr. Hornaday and accept full financial responsibility regardless of insurance coverage. If I am not the patient listed on this form, I certify that I am the **legal guardian/health care representative** of the patient listed on this form and have legal authority to make healthcare decisions for this patient.

Signed: _____ _____ Date: _____
Patient or Legal Guardian Signature Relationship to Patient

Print Name: _____

Patient Information

Anthony J. Hornaday, D.D.S.
Oral and Maxillofacial Surgery

The following several paragraphs pertain to all Oral and Maxillofacial Surgery procedures.

I realize the importance of supplying true and accurate information about my health, especially concerning possible pregnancy, allergies, medications, and history of drug or alcohol abuse. I understand that if I misinform my doctor the consequences may be life threatening or otherwise adversely affect the results of my surgery.

While performing my surgery I recognize that Dr. Hornaday may discover other or different conditions than expected. This may require different or additional procedures than those planned or may require termination of my surgery. I authorize Dr. Hornaday to perform such other procedures as he deems medically and/or surgically necessary in his professional judgment or to stop my procedure.

I consent to the administration of anesthetics and medications as may be deemed necessary or advisable for my comfort, health, and safety. If general anesthesia is used, I understand that there may be soreness, redness, swelling, and/or bruising at or around the IV site or along the vein that may require additional treatment. Other rare complications of IV anesthesia may include allergic reaction to medications, respiratory problems that may require a breathing tube be placed, stroke, heart attack, heart failure, and/or death.

I am also aware that oral sedation, intravenous (IV) sedation, general anesthesia, and many drugs are not recommended for use for women who are pregnant. I understand that it is my responsibility (or the responsibility of a parent or legal guardian of a female patient) to advise Dr. Hornaday if I am pregnant or possibly could be pregnant.

I also have been informed by Dr. Hornaday that antibiotics *can* and *may* interfere with the effectiveness of birth control and that I *can* and *may* become pregnant if another form of contraception is not used. I also understand and have been informed that if antibiotics are used in my care I will need to use another form of contraception and should consult my medical doctor.

I understand that there are two Oral Surgeons at this office, Dr. Anthony J. Hornaday and Dr. James E. Hornaday. I understand that the procedure may be performed by either doctor and I give my consent for the procedure to be performed by either doctor.

I have been made aware that certain medications, drugs, anesthetics and prescriptions that I may be given can cause drowsiness, and lack of awareness and coordination which also may be increased by the use of alcohol and other drugs. I understand that I should not use alcohol, operate a vehicle or other hazardous machinery, or make any legal decisions while under the influence of any medication, anesthesia, or prescription given by this office. I have been advised not to return to work while taking such medications, or until fully recovered from the effects of such medications, drugs, anesthetics and/or prescriptions. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am given sedative medication for my surgery, I agree not to drive myself to the appointment or home afterwards and will have a responsible adult drive me to the appointment and home and accompany me until I am fully recovered from the effects of the sedation.

I certify that I have read and fully understand the terms and words in the above consent and /or any verbal explanations given to me by my doctor and/or his assistants, and that I give my consent voluntarily. If I am not the patient listed on this form, I certify that I am the **legal guardian/health care representative** of the patient listed on this form and have legal authority to make healthcare decisions for this patient.

Patient_____ Patient's Signature _____ Date _____

Parent or Legal Guardian Signature _____ Date _____

Witnessed By _____ Date _____

Anthony J. Hornaday, D.D.S.
Oral and Maxillofacial Surgery

Information Regarding Pain Clinics, Pain Contracts, and Controlled Substances

Patient Name: _____
First Middle Last Nickname

Date of Birth: _____/_____/_____ Age: _____ Sex: Male Female

1. Are you currently, or have you ever been, under a pain contract?
   If so, with whom?

2. Are you currently receiving narcotic medications (i.e. Ultram, Tramadol, Norco, Vicodin, Lortab, Lorcet, Hyrdocodone, Percocet, Oxycodone, OxyContin, MS Contin, Fentanyl, Fentanyl Patch, Morphine, Dilaudid...)?
   If so, please list:

3. Are you currently being treated for, or have you ever been treated for, narcotic or any substance abuse?
   If so, please explain:

4. Are you currently taking, or have you ever taken, medications such as Suboxone or Methadone?
   If so, please explain:

Please note that this office does routinely use INSPECT; an INSPECT report summarizes the controlled substances a patient has been prescribed, the quantity of medication, the date the medication was prescribed/filled, the practitioner who prescribed them, and the dispensing pharmacy where the patient obtained them.

Falsifying information regarding your controlled substance use and/or pain clinic/pain contract involvement can have adverse health effects leading to serious complications, hospitalization, and even death. **Falsifying this information or not being completely honest with regards to this information will result in cancellation of your appointment and permanent dismissal from this office and may also result in dismissal by your pain clinic/doctor and no further prescriptions being dispensed to you.**

Patient_____ Patient's Signature _____ Date _____

Parent or Legal Guardian Signature _____ Date _____

Witnessed By _____ Date _____

Anthony J. Hornaday, D.D.S.
Oral and Maxillofacial Surgery of East Central Indiana
620 S. Tillotson Avenue ♦ Muncie, IN 47304 ♦ (765) 289-9705

CONSENT FOR EXTRACTION OF TEETH

Patient Name: Date:

It is required that all patients read and sign consent prior to any treatment. In order for you to give your consent to treatment we feel strongly that you, as the patient, should be given as much information as possible regarding that treatment. We have found that our best patients are our most informed patients. This information is not meant to alarm you, but rather allow you to make an informed decision. We also feel that you should have an opportunity to ask questions and receive satisfactory answers to those questions. We ask that you please take your time and read the following form completely.

Extraction of teeth is an *irreversible* process, and whether routine or difficult, is a surgical procedure. As in any surgery, there are some potential risks and complications. These include, but are not limited to, the following:

1. Swelling, bruising and/or discomfort.
2. Stretching of the corners of the mouth resulting in cracking or bruising.
3. Possible infection requiring additional treatment, including hospitalization.
4. Injury to nerves: In the lower jaw there is a nerve canal for a nerve (inferior alveolar nerve) that supplies feeling to the lower lip, chin, tongue, teeth, gingiva (gums), and cheek. There is also a nerve (lingual nerve) that lies outside the lower jaw that supplies feeling to the tongue. There is a possibility that these nerves could be bumped, bruised, cut, or damaged during the removal of lower teeth, especially 3rd molars (wisdom teeth). If injury were to occur to any one of the previously mentioned nerves, numbness of the lower lip, chin, tongue, teeth, gingiva (gums), and/or cheek could occur. Injury to these nerves can also cause pain (dysesthesia) which can persist indefinitely. Injury to these nerves and the above listed symptoms can also be caused by the local anesthetic injection even if no teeth are removed and no surgery performed. *Usually*, injury from the removal of teeth and/or the injection is temporary, but it **could be permanent**. Numbness of the tongue would also result in loss of taste.
5. Dry socket (Alveolar Osteitis) – failure of a normal blood clot to form in the extraction site causing jaw pain, usually requiring additional care.
6. Possible damage to adjacent teeth, especially those with large fillings or crowns, requiring replacement of the filling or crown, extraction, or root canal therapy of the tooth/teeth involved.
7. Injury to the temporomandibular joint (TMJ): Removal of teeth may produce pain, clicking, and/or limitation of motion (trismus). If you have a preexisting TMJ disorder Dr. Hornaday should be notified **before** surgery. Removal of teeth can aggravate a preexisting problem with your TMJ even with the gentlest of care. If a problem with your TMJ should occur further treatment may be necessary.
8. Heavy bleeding. This may require hospitalization and/or a general anesthetic to resolve.

Patient_____ Patient's Signature _____ Date _____

Parent/Legal Guardian/POA Signature _____ Date _____

Witnessed By _____ Date _____

9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.

10. Incomplete removal of tooth fragments: to avoid injury to vital structures such as nerves, vessels, or sinus, tooth roots may be left in place. Rarely, these fragments of tooth may require an additional procedure to remove if they become infected.

11. Sinus involvement: the roots of upper back teeth are often close to the maxillary (upper jaw) sinus and sometimes a piece of the root or entire tooth can be displaced into the sinus which would require additional surgery and/or hospitalization. An opening from the mouth into the maxillary sinus and/or an infection can occur which may require additional surgical procedure(s) and/or hospitalization.

12. Displacement of an upper tooth into a space behind the upper jaw called the infratemporal fossa. This may require hospitalization and a general anesthetic to remove.

13. Jaw fracture - while quite rare, it is possible with removal of impacted teeth or in people with atrophic (small) mandibles (lower jaw). This would require wiring the jaws together and/or hospitalization for an open reduction and internal fixation (application of plates and screws) of the jaw.

14. Nausea and/or vomiting, usually due to medications

15. Accidental swallowing of a tooth, filling, or other foreign material that may require X-Rays at the hospital to determine where the material lodged. Additional procedures and/or general anesthetic may be required to remove the object.

16. I understand when teeth are removed that a space is created. I understand that adjacent teeth either next to or opposing the space may migrate or supererupt into the space which may lead to their removal also if nothing is done to replace the extracted teeth.

17. I understand that no warranties or guarantees of any kind have been made to me or anyone about the results of my surgery or procedure(s). I have been given adequate opportunity to read this entire form and to ask any questions about my surgery or procedure(s) before signing this form. I understand that it is my responsibility to inform my doctor if I wish to try another method of treatment to keep my tooth/teeth rather than undergo surgical intervention. I have been informed of the reason for my surgery, the risks involved, and possible alternate methods of treatment, if any, and I elect to undergo the treatment Dr. Hornaday has proposed.

18. I understand and agree that this consent form is valid for all future procedures unless the content changes, at which time I will be given an updated consent form.

I certify that I have read and fully understand the terms and words in the above consent and /or any verbal explanations given to me by my doctor and/or his assistants, and that I give my consent voluntarily. If I am not the patient listed on this form, I certify that I am the **legal guardian/health care representative** of the patient listed on this form and have legal authority to make healthcare decisions for this patient.

Patient_____ Patient's Signature _____ Date _____

Parent/Legal Guardian/POA Signature _____ Date _____

Witnessed By _____ Date _____

Anthony J. Hornaday, D.D.S.
Oral and Maxillofacial Surgery of East Central Indiana
620 S. Tillotson Avenue ♦ Muncie, IN 47304 ♦ (765) 289-9705

Medical/Protected Health Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

[ ] I authorize the release of my medical and protected health information from Anthony J. Hornaday, D.D.S. including all medical records, diagnoses, examination/test results, treatment, appointment times and information, claims information, and fees charged.

This information may be released to:

[ ] Spouse_____

[ ] Children_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: **[ ]** my home **[ ]** my work **[ ]** my cell Number: _____

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ___/____/_____

Acknowledgment of Receipt of Notice of Privacy Practices

Anthony J. Hornaday, D.D.S.

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

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
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

_____

_____

_____

Medicare Private Contract
for the Patients of Anthony J. Hornaday, D.D.S.

This Medicare Private Contract ("Agreement") dated as of _____20___, ("Effective Date") is made by and between **Anthony J. Hornaday, D.D.S.**, ("Dr. Hornaday") whose principal office is located at 620 S. Tillotson Ave., Muncie, IN 47304, and _____, ("you" or "the beneficiary, or his or her legal representative,"), who resides at _____(your address).

1. **Explanation**. Dr. Hornaday is no longer a participating physician with Medicare under the Social Security Act. This document explains Dr. Hornaday's rights and obligations as your physician, and your rights and obligations as Dr. Hornaday's patient. This contract is specifically limited to the financial agreement between you and Dr. Hornaday and does not obligate you or Dr. Hornaday to a specific medical treatment. A change in the Social Security Act, effective January 1, 1998, permits physicians and their Medicare patients, or their legal representatives, to enter into private written contracts regarding benefits. Beneficiaries, or their legal representatives, and physicians who take advantage of these private written contracts are not allowed to submit claims to Medicare, or to expect payment from Medicare. This applies only when you have a written private contract with a physician. It does not apply for other physicians that you see, unless you enter into a similar contract with those physicians.

You are not required to enter into a private contract with Dr. Hornaday, or with any physician that does not participate in the Medicare program. If you wish to continue to have your medical services paid under your Part B Medicare coverage, do not sign this agreement and transfer your care to another physician that is participating in the Medicare Part B program.

2. **Beneficiary Status**. You are a beneficiary currently enrolled in Medicare Part B or a beneficiary that may become enrolled in Medicare in the future. If you are not currently a Medicare beneficiary, this Agreement is applicable to you only upon your enrollment in Medicare.

3. **Dr. Hornaday's Status**. Dr. Hornaday has not been excluded from providing Medicare services. Dr. Hornaday has personally decided not to participate in Medicare.

4. **Dr. Hornaday's Obligations**.

   a) Dr. Hornaday will provide medical treatment to you that you have agreed to receive.

   β) Dr. Hornaday will not submit any claims to Medicare for any items or medical services that he provides, even if they are covered by Medicare.

   χ) Dr. Hornaday will not execute this Agreement when you are facing a medical emergency or urgent health care situation.

   δ) Dr. Hornaday will provide you with a copy of this Agreement before he provides medical services to you.

   ε) If the Centers for Medicare and Medicaid Services ("CMS") request a copy of this document, Dr. Hornaday will provide a copy to CMS.

5. **Beneficiary Obligations**.

   a) The beneficiary, or his or her legal representative, agrees to be fully responsible for payment of all items or services furnished by Dr. Hornaday. The beneficiary, or his or her legal representative, understands that no Medicare reimbursement will be available for Dr. Hornaday's services or any items furnished by him.

   b) The beneficiary, or his or her legal representative, and Dr. Hornaday agree that limits under the Medicare program do not apply to amounts which Dr. Hornaday may charge the beneficiary, or his or her legal representative.

χ) The beneficiary, or his or her legal representative, agrees not to submit a claim to Medicare and agrees not to ask Dr. Hornaday to submit a claim to Medicare for services provided to the beneficiary.

d) The beneficiary, or his or her legal representative, understands that due to this private contract, Medicare payment will not be made for any items or services furnished by Dr. Hornaday. This applies to services which normally would be reimbursable under Medicare if this Agreement were not in place.

e) The beneficiary, or his or her legal representative, understands that this contract pertains to Dr. Hornaday's services only and that Medicare covered medical services may be obtained from other physicians who have not opted out of Medicare. This contract does not apply to relationships which the beneficiary, or his or her legal representative, has with other physicians.

f) Medigap plans under Section 1882 of the Social Security Act will not pay for services or items provided by Dr. Hornaday, since they are not covered by Medicare. It is also possible that other supplemental insurance plans may not pay for services or items provided by Dr. Hornaday, since they are not covered by Medicare.

6. **Term and Termination**. This document shall begin as of the Effective Date and be effective for one (1) year from the Effective Date (the "Initial Term"). **AT THE CONCLUSION OF THE INITIAL TERM OF THIS AGREEMENT, AND AT THE CONCLUSION OF EACH SUCCESSIVE RENEWAL TERM OF THIS AGREEMENT, THE TERM OF THIS AGREEMENT SHALL BE AUTOMATICALLY EXTENDED FOR ADDITIONAL ONE (1) YEAR PERIODS** (each, a "Renewal Term"). This Agreement shall automatically terminate upon the first to occur of the following: (1) Dr. Hornaday's election to participate in the Medicare program; (ii) in the event that Dr. Hornaday or the beneficiary, or his or her legal representative, violate any of the items set forth herein; or (iii) upon thirty (30) days prior written notice from one party to the other party; provided, however, that all amounts owned for items or services provided prior to the termination of this Agreement are the responsibility of the beneficiary, or his or her legal representative.

7. **Indemnification and Successors and Assigns**. The parties agree that this Agreement shall be fully binding upon their successors and assigns and that the beneficiary, or his or her legal representative, will indemnify and defend Dr. Hornaday against any claims, losses, liabilities or costs incurred as a result of any services provided to the beneficiary, or his or her legal representative, under this Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the Effective Date first written above.

Anthony J. Hornaday, D.D.S. Name of Provider	Name of Beneficiary
Signature of Provider	Signature of Beneficiary
620 S. Tillotson Ave., Muncie, IN 47304 Principal Office Address	Beneficiary's Legal Representative
1407897523 National Provider Identifier (NPI)	Beneficiary's Legal Representative's Signature