# Informed Consent For General Dental Procedures, Cancellation Policy, and Financial Policy

**The following is a statement of our Informed Consent for General Dental Procedures and Cancellation Policy. We require that you read, agree to and sign prior to any treatment.**

**Informed Consent:**

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally. Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

- Pain, swelling, and discomfort after treatment;
- Infection in need of medication, follow-up procedures or other treatment;
- Temporary, or, on rare occasions, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with the possible loss of taste;
- The need for replacement restorations, implants, or other appliances in the future;
- An altered bite in need of adjustment;
- Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist;
- A root tip, bone fragment, or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop;
- If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need of further treatment;
- Allergic reaction to anesthetic or medication;
- Need for follow-up care and treatment, including surgery.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

**Missed Appointment(s) and Cancellations:**

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 48-hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

**The following is a statement about our Financial Policy. We require that you read, agree to and sign prior to any treatment.**

**Please note:** Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and the Dental Fee Plan by Capital One. Additional fees will be applied for returned checks. All account balances over 90 days are subject to a late fee.

***If you pay by cash:***

- This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.
- The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur.

***If you have insurance:***

- As a courtesy to you, we will help you process all of your dental insurance claims. We will provide an insurance estimate to you. Please understand, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. For those services not covered by your insurance, you will receive a Good Faith Estimate showing the expected cost of those items and services based on information known at the time the estimate was created.
- All charges you incur are your responsibility, regardless of your insurance coverage. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. You authorize the release of any information concerning your (or your dependent's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- Deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, is due at the time we provide the service(s) to you.
- Insurance payments are ordinarily received within 45-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected.
- If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

**Minors accompanied by the parent or legal guardian:** The parent or legal guardian accompanying a minor, who has consented to treatment, are responsible for full payment at time of service.

**Unaccompanied Minors:** The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

**Communications with you:** In order to enhance patients' care and experience with us, we may contact you after your visit in order to request feedback on your experience by phone call, SMS text message, e-mail, voicemail, or mobile application, some of which may be via automated means. We may also listen to and record phone conversations with us for training purposes or to evaluate the quality of our service. By signing below you understand and agree to be contacted in this manner with communications related to this visit, and any future visits. In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you.

**Consent:**

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and paid at the time services are rendered.

**Patient /Guardian Signature:** _____ **Date:**

**Office Staff Signature:** _____ **Date:**

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Dental Practice will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

**Patient Name:** **Acct Number:**

**Address:**

**City:** **State:** **Zip Code:**

**E-mail:** **Phone:**

**Doctor's Name:** **Practice Name:**

**Practice Address:**

I hereby authorize the doctor and practice listed above to release the dental information of the patient named above to:

Print Name of Recipient: _____

Address City State Zip

Specify the dental information to be disclosed above:

**Purpose:** The dental records and information disclosed may only be used for the purpose(s) listed above:

**Duration:** This authorization shall remain in effect for one year from the date of my signature below unless a different date is specified here_____(date).

**Revocation:** You or your personal representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of your written request to revoke.

**RediscloSure:** I understand that information disclosed pursuant to this authorization may no longer be protected under federal privacy law (HIPAA) and could be re-disclosed by the recipient.

A copy of this authorization is as valid as the original. I have the right to receive a copy of this authorization.

Date Signature If Signed by Other than Patient, Indicate Relationship