CITY ENDODONTICS P.L.L.C.

Consent to Treatment

There are some risks in all dental procedures. Specific risks include but are not limited to: infection, swelling, pain, discoloration, and partial or complete permanent of transient numbness or parathesia of areas of the oral cavity. Sometimes there are complications that cannot be foreseen. If we are not able to resolve your chief complaint, we will assist you in finding a specialist that can accommodate your needs.

Alternate methods of treatment and the consequences of treatment will be explained. The procedures involved in dental treatment include the use of anesthetics, sedatives and other medications. Changes in any treatment plan will be discussed with you for your approval.

You may ask questions regarding any proposed procedure and the risk involved, and you have the right to refuse any procedure.

My signature below indicates that I have read and accepted the above statements.

Signature of Patient, Parent/Guardian

_____

Printed Name

_____

Date

_____

FEE INFORMATION

We are committed to providing you with the best possible dental care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits.

It is important that you realize…

1. Your dental benefit program is a contact between you, your employer, and the insurance company. **We are not a party to that contract.** This office files your insurance as a courtesy to you.
2. Our fees generally, but not necessarily, fall within the usual, customary and reasonable fee structure determined by your insurance benefits.
3. Not all dental services are covered benefits.
4. **You (not the insurance company) are responsible for all the fees for services rendered to you by City Endodontics. A standard $150 consultation fee is assessed upon a first visit basis.**
5. For patients who have insurance, an **ESTIMATE** will be given for the benefits at the time services are rendered. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage table is lower than average. It is your responsibility to understand your insurance coverage. This includes co-payments and co-insurance. Please contact your insurance company if you have questions.
6. If your account is delinquent, you will be responsible for ALL Attorneys fees, Collection Fees and any Interest that occurs on your account during the collection process. **If you have paid with a credit card in the past and you have an account balance 30 days overdue, you give us permission to charge that card the full owed balance to our office.**

We value your time as well as ours. We will strive not to keep you waiting; however, unforeseen circumstances do arise. We will inform you if there will be a delay. If unable to keep an appointment please call our office within 24 hours so we can assist other patients.

Signature of Patient, Parent/Guardian

_____

Printed Name _____

Date _____

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PATIENT HIPPA CONSENT FORM

In response to the misuse of Personal Health Information (PHI), the Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI is kept private. This rule was also to established in order to provide a standard for health care operation.

We want you to know that we respect the privacy of your medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your PHI in order to provide health care that is in your best interest.

We support your full access to your personal medical records. You should be aware that we may have indirect treatment relationships with you that include but not limited to laboratories, pharmacies and other medical offices. As such, we may need to discuss PHI for purposes of treatment, payment and/or other health care operations. These outside entities do not necessarily need to obtain your consent for these communications. By signing below, you consent to diagnostic x-rays to be performed at City Endodontics and if needed, to the release of these and relevant medical history for further review at the discretion of City Endodontics.

You have the right to refuse to consent to the use or disclosure of your PHI. This refusal must be in writing. Under the HIPPA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI, by signing this document, you can at some future time request to refuse disclosures of your PHI. This refusal must be in writing. However, you may not revoke actions that have already been taken, which relied on this or a previously signed consent.

You may receive a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our Compliance Office if you have any objections to this consent.

Patient Signature

Date