All Smiles
FAMILY DENTAL, PLLC

CONSENT FOR TREATMENT

My signature below gives consent for the dentist and/or employee of All Smiles Family Dental, PLLC to perform any necessary dental procedures.

Patient/Guardian Signature: _____ DATE: _____

CONSENT FOR NITROUS OXIDE

I give my consent for the use of Nitrous Oxide (laughing gas/happy air) as deemed appropriate by the dentist to help control anxiety for myself or my child during dental treatment. I have been informed that the Nitrous Oxide may take my child or me "tingly" or "floaty" and that the Nitrous Oxide will be completely dissipated from the patients' system after 2 or 3 minutes of breathing room air. I also understand that, while it rarely occurs; nausea is a possible adverse effect of the Nitrous Oxide.

Patient/Guardian Signature: _____ DATE: _____

INSURANCE/PAYMENTS

I understand that if I have not secured appropriate authorization and otherwise complied with the terms of my insurance benefit plan, there may be a decrease in my coverage or no coverage at all for some or all of the services which I am about to receive and I WILL BE RESPONSIBLE for all non-covered services; and if I do not provide insurance information to be filed on my behalf, I will be FINANCIALLY RESPONSIBLE for all services. ***CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE***

I understand that I am responsible for all services rendered, regardless of insurance coverage or third party liability, when services are rendered. I agree to pay all cost of collection including reasonable attorney fee and court cost in the event it becomes necessary to pursue the account for collection. A billing statement will be sent every month until there is a "0" balance on the account. If insurance has been filed, please allow 4-6 weeks for payment to be reflected on the billing statement before calling the office.

Authorization to Release Information: I authorize the release of any medical information or any other necessary information to process claims.

Patient/Guardian Signature: _____ DATE: _____

CANCELLATIONS OF APPOINTMENTS/NO SHOWS

Last minute cancellation, same day cancellation and same day no-show make it difficult to serve other patients who are waiting to be scheduled. We require you to give a forty-eight (48) hour cancellation notice prior to your appointment if you are unable to keep that appointment. In the event that you are unable to provide the forty-eight (48) hour notice for cancellation, payment may be required in advance before we are able to reserve another appointment. ***Failed appointments will be reported to insurance carriers that request notification.*** After one failed appointment, we will no longer be able to provide family appointments; after three (3) cancellation/no-show occurrences, this practice may elect to change the terms of our relationship with you. If you arrive 15 minutes late for your scheduled appointment, you will need to reschedule.

I understand that it is my sole responsibility to reschedule appointments in advance when necessary, and that failure to do so may result in the office's inability to reserve my appointments in advance.

Patient/Guardian Signature: _____ DATE: _____

MINORS MUST BE ACCOMPANIED

I understand that I must accompany my child to all dental appointments until his/her eighteenth (18th) birthday. It is my responsibility to provide written consent for another adult, age eighteen (18) or older, to accompany my child to his/her appointments if/when I am unable to be present. I also understand that written consent authorizes the accompanying adult to give consent to dental treatment, access pertinent medical information, and take full responsibility for my child. Failure to provide this authorization may result in my child's appointment being rescheduled. This consent can be changed or terminated at any point when/if I decide that the adult listed is no longer a suitable escort and must be provided as written notice.

Patient/Guardian Signature: _____ DATE: _____

CONSENT TO DETAILED MESSAGES

I hereby grant All Smiles Family Dental, PLLC permission to leave detailed information regarding appointment dates and times, cost of treatment, and other general information in the following formats listed below:

Cell Phone: _____ ☐ Voicemail ☐ Text **Email:** _____

Home Phone: _____ ☐ Voicemail **Adult:** _____

It is my responsibility to update any changes to this list, and I will not hold any representative of All Smiles Family Dental, PLLC responsible if personal information is disclosed to any of the sources listed above when I have failed to provide written notice of any changes.

Patient/Guardian Signature: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You may refuse to sign this acknowledgement

I have received a copy of this office's *NOTICE OF PRIVACY PRACTICE.* I understand that this organization has the right to change its *NOTICE OF PRIVACY PRACTICE* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *NOTICE OF PRIVACY PRACTICE.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my restriction requests, but if you do agree you are bound to abide by such restrictions.

PATIENT NAME: _____ RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

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