**Consent for Services**

Please initial after each statement acknowledging that you have read and agree to the contents.

* I hereby authorize the doctor and/or staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or my child's dental condition(s).
* Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
* I agree to the use of local anesthetics, sedatives, and other medications as necessary. I fully understand an anesthetic agent embodies certain risks.
* I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

**Financial Policy**

Thank you for choosing our office as your dental care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

* **Full payment is due at the time of service.** We accept Cash, Personal Check, Visa, MasterCard, Discover, and Debit Cards. Please be aware that **a $35.00 fee will be charged for all returned checks.**
* We are a Fee for Service Office meaning **we do not accept payment from dental insurance companies**. However we can help you with everything you need to file a claim with your own insurance company.
* I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependant(s) to third-party payers, and/or healthcare practitioners.
* I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

**BROKEN APPOINTMENT POLICY:** When you make your appointment, the doctors' and staffs' time is specifically reserved for you.

* **24 hour notice for cancellation:** I agree to give 24-hour notice for cancellations or pay the **$50 per hour broken appointment charge**. I understand that leaving a message after the office is closed the day (or weekend) before is **NOT** sufficient notice. **Hygiene appointments:** If I am more than 15 minutes late for my cleaning appointment, I will either take my remaining time or reschedule and pay **$50 per hour broken appointment charge**.
* **Appointments cancelled short notice**, for non-emergency reasons, will be subject to a **$50 per hour broken appointment charge**. Repeated late cancellations or broken appointments will result in dismissal from the practice.
* We make our best efforts to respect your time by staying on schedule. Please help us to do this by arriving on time to your appointment and promptly notifying us of any delays. If you are late for your appointment and we do not have adequate time left for your procedure your appointment will be rescheduled. Repeated late appointments will result in dismissal from the practice as they are disruptive to our schedule.
* COFIRMING APPOINTMENTS: we do require you to contact us through phone, or email to confirm your appointment. If we do not hear from you at least 24 hours before your appointment we reserve the right to give that allotted time to another patient.

**Patient Consent Form/HIPPA Privacy Form**

This form protects your health information. We encourage you to read it thoroughly. At no time do we ever sell or give away any of our patient’s personal information.

**Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Florida Integrative Dentistry

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to us here Florida Integrative Dentistry. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form, Financial Policies and your Notice of Privacy Practices. I understand that, by signing this Consent form, I agree to comply with these policies and am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

If this Consent is signed by someone other than the patient, please complete the following:

Printed name of person completing form:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:

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**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT**