All Smiles
FAMILY DENTAL, PLLC

GENERAL TREATMENT CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasant smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment but should be considered when making treatment decisions.

Benefits of dental treatment can include relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are common risks associated with virtually any dental procedure, including:

- Drug or chemical reaction – Dental materials and medications may trigger allergic or sensitivity reactions.
- Long-term numbness (paresthesia) – Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
- Muscle or joint tenderness – Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
- Sensitivity in teeth or gums, infection or bleeding.
- Swallowing or inhaling small objects.

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions regarding all dental procedures that are recommended to you.

I have read and understand the statement on this page and consent to dental treatment which I have accepted.

Patient/Guardian Signature: _____ Date: _____

Patient Name (print)**: _____ Relationship to Patient: _____**

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INSURANCE BENEFITS & INSURANCE BENEFITS PAYMENTS

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. **Initials: _____**

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is your responsibility to know if our office is participating or non-participating with your insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, co-insurance and deductibles as outlined by your insurance carrier. **Initials: _____**

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary. Our fees are well within such ranges, and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier. **Initials: _____**

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit additional information requested by your insurance carrier to finalize an outstanding claim and your cooperation is lacking, we will close the claim on our side and charge you the outstanding insurance balance for that claim. We reserve the right to impose an administrative fee if we are requested by you to re-open and refile on your behalf. **Initials: _____**

CANCELLATION OF APPOINTMENT

If you are unable to keep your pre-reserved appointment, the office requires a forty-eight (48) hour cancellation notice prior to the reserved appointment time. When our time is lost to nonproductive appointments, we are forced to increase our fees to remain profitable. If you are unable to provide the forty-eight (48) hour notice for cancellation, pre-payment for future appointments may be requested. **Initials: _____**

FAILED APPOINTMENT

Missed appointments do occur from time to time. We reserve our time specifically for you. Your dental needs dictate the amount of time we schedule to deliver high quality dental services to you. After a missed appointment, the office may elect to change the established patient-provider relationship. I understand that arriving late for my scheduled appointment may result in my appointment being rescheduled to a later date. **Initials: _____**

Patient/Guardian Signature: _____ Date: _____

Patient Name (print)**: _____ Relationship to Patient: _____**

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CONSENT TO DETAILED MESSAGES

I hereby grant the office permission to leave detailed information regarding my dental care and treatment needs.

Patient Name (print)**: _____ Relationship to Patient: _____**

I wish to be called at HOME ☐ and/or CELL ☐ (check all that apply) regarding my care and follow up.

The best phone number(s) to reach me are: HOME: _____ CELL:

_____

I do ☐ / I do not ☐ give permission to leave relevant dental information on my message service, answering machine or voicemail.

I do ☐ / I do not ☐ give permission to share relevant dental information with the person who may answer the telephone.

The name(s) and their relation to you with whom you give us permission to leave pertinent information is/are printed below:

Name: _____ Relation: _____

Name: _____ Relation: _____

It is your responsibility to update the office with any changes regarding this list in writing. Failure to update contact names may result in personal information being shared inadvertently.

Patient/Guardian Signature: _____ Date: _____

Patient Name (print)**: _____ Relationship to Patient: _____**

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PHOTOGRAPHY CONSENT (optional)
I authorize the use and disclosure of my name, photographic images, video images, and/or testimonial for marketing purposes by **All Smiles Family Dental, PLLC** and/or by either **Kelbin Rodriguez, DDS** or **Tanya Felton, DMD**. I understand that this authorization may be subject to redisclosure and HIPAA privacy regulations may no longer apply if I elect to disclose this information. These images and/or testimonials may be used for the following purposes: professional portfolios, educational purposes, social media networking platforms, marketing and advertising.

I understand that I may revoke this authorization at any time. This revocation must be in writing and received by the practice via registered mail. If I elect to revoke this authorization in the future, it will not be retroactive. This authorization expires 99 years from date signed.

I understand that the practice cannot condition treatment based on whether I sign this authorization.

- I would like a copy of this form ☐ Yes ☐ No
  (Copy provided by _____)
  Employee Initial

Patient/Guardian Signature: _____ Date: _____

Patient Name (print)**: _____ Relationship to Patient: _____**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You may refuse to sign this acknowledgement

I have received a copy of the office's *NOTICE OF PRIVACY PRACTICE*. I acknowledge that the office 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 below to obtain a current copy of the *NOTICE OF PRIVACY PRACTICE*. I understand that I may request in writing that the office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the office is not required to agree to my restriction requests; if the office agrees with my requests, the office will be bound to abide by such restrictions.

Patient/Guardian Signature: _____ Date: _____

Patient Name (print)**: _____ Relationship to Patient: _____**

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