Committed to Excellence in Dentistry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of [Hood Dental Care]'s Notice of Privacy Practices, which has an effective date of **09/23/13**, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

____ __________________________
Signature of Patient or Patient's Representative Date

____
Print Name

____
Relationship to Patient (If not signed by the Patient)

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CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT FOR RECEIPT OF INFORMATION

State law required us to obtain your consent for the contemplated dental treatment. What you are being asked to sign is confirmation that we have discussed the nature purpose of your contemplated treatment and the risks associated therewith. Ask about anything you do not understand. We will be pleased to explain.

Including any necessary of advisable anesthesia.

<u>ALTERNATIVES TO THE RECOMMENDED DENTAL TREATMENT:</u>

Alternative to the recommended treatment, including no treatment, have been explained to me as have the advantages and disadvantages of each.

<u>RISKS ASSOCIATED WITH RECOMMENDED DENTAL TREATMENT:</u>

I understand that dentistry is not an exact science and that complications may occur despite our best efforts. A partial listing of the risks known to be associated with this treatment and with the associated anesthetic are:

- Change of bite
- Loss of Taste
- Swallowing of objects
- Drug/Allergic Reaction
- Dry Socket
- Infection
- Breakage of Root(s)
- Retained Root Fragment(s)
- Loss/Damage to Adjacent teeth and bone
- Fracture or Breakage of Jaw
- Sinus Involvement
- Further surgery or treatment
- Pain
- Instrument Breakage
- Trismus (Jaw pain or difficulty opening mouth)
- Swelling & bruising which may necessitate staying home for several days
- Retained Instrument Fragment(s)
- Paresthesia (Permanent or transient numbers of the cheeks, gums, teeth, lips, tongue, chin, and face)
- Stretching of mouth which may result in cracking and/or bruising
- Failure of the treatment to accomplish its purpose
- Bleeding which may be heavy enough to stop procedure
- TMJ Dysfunction or worsening of TMJ condition

State law requires that I specifically advise you that, although rarely occurring, the dental treatment of anesthetic may result it: Death, Brain Damage, Quadriplegia, Paraplegia, Loss of Organ(s), Loss of Function of Face, Arm(s), or Leg(s) and Disfiguring Scars.

Please turn over to sign for the acknowledgement of this consent.

ACKNOWLEDGEMENT

I acknowledge that I have read and understand the information on both pages of this consent form (or that it has been read to me). I understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I had about the treatment. All of the questions about the treatment have been answered in a satisfactory manner.

I understand that the success of this treatment and the avoidance of treatment complications depends to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me, my following of them, and keeping the appointments for the treatment follow-up office visits scheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complication(s), where further treatment may be discussed, or administered, which I not currently anticipated.

I hereby authorize and direct E. Edward Hood, Jr., D.D.S. and/or associates or assistants of his or her choice, to perform the diagnostic, surgical, or dental treatments. This consent form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature. I waive any further disclosures or information.

Date ____________________

Signature of Patient ____

Signature of Relative (if required) _____________________________________

Signature of Witness ____

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AUTHORIZATION AND RELEASE

I, ________________________________ do hereby authorize and release to the following: diagnosis, dental findings, information including, but not limited to the following: diagnosis, dental findings and procedures, radiographs, images, photographs, diagnostic models and additional materials.

In consideration of such disclosure on the part of the above named person of institutions, I hereby release them from any and all liability arising from such disclosures.

Patient Signature ____________________________________ Date_______________

Witness Signature __________________________________ Date_______________

YOUR DENTAL INSURANCE IS YOUR RESPONSIBILITY…BUT WE CAN HELP…….regardless of what we might calculate as your dental benefit in dollars. We must stress the fact that you, the patient, are responsible for the TOTAL TREATMENT FEE. As a courtesy to you, we do accept assignment of benefit payments from most insurance companies. This will reduce you immediate, out-of-pocket expenditures. Our estimate is based on limited information obtained from your insurance company. We allow 45 days for your insurance company to make payment. AFTER THIS TIME ALL INQUIRES (FOLLOW UP) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

Signature ___________________________________ Date ______________

Patient Agreement

Please initial and sign

________ **As a courtesy to our patients using insurance; we are happy to file claims. All benefits quoted are estimates only and not a guarantee of payment. If you have questions regarding your coverage, please contact your insurance company directly.**

________ If insurance coverage is terminated or has not been updated with Hood Dental Care; the patient will be responsible for all incurred charges.

________ **Hood Dental Care provides the most up to date services. These services include, but are not limited to, composite (tooth colored fillings), same day crowns and cosmetic dentistry. Insurance companies may not cover all procedures. In these cases, the patient will be responsible for any unpaid balances.**

________ Treatment plans and associated fees may change without notice if it is in the best interest of the patient at the time of treatment.

________ **All estimated fees are due at the time of treatment. We are happy to discuss finance options. All financial arrangements must be made before any treatment is rendered.**

________ Appointments that are over 90 minutes require a 10% deposit prior to scheduling.

________ **After ninety days, all outstanding balances will be forwarded to our collection agency.**

________ One American dies every hour due to oral cancer. For this reason; we conduct an oral cancer screening once per year starting at the second scheduled exam. If your dental insurance does not cover this procedure; the patient will be billed $40.00.

________ **I authorize and give consent to Hood Dental Care to perform the dental services agreed between doctor and patient or parent/guardian to be necessary and advisable including the use of local anesthesia and other medications as indicated.**

I understand that I am ultimately responsible for all services rendered. In the case of default, I am responsible for the cost of attorney's fees, court costs, the cost of collection proceedings and I waive the right to have any amounts owed discharged in bankruptcy.

Date ______________ **Signature______________________________**