

# ESSENCE OF DENTISTRY

## A New Dimension in Oral Health Care

### INFORMED CONSENT

All patients complete 1 thru 4, and 5 thru 10 as needed.

#### 1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan

#### 2. DRUGS, MEDICATIONS, AND SEDATION

I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours, or until fully recovered from the effects of the anesthetic, medications and drugs that may have been given me in the office for my care. I understand that failure to take medication as prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain, and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

#### 3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

#### 4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment, wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

#### 5. FILLINGS

I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common aftereffect of a newly placed filling.

#### 6. REMOVAL OF TEETH

Alternatives to removal have been explained to patient (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons noted in paragraph # 3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist, or even hospitalization, if complications arise during or following treatment, the cost of which is my responsibility.

#### 7. CROWNS, BRIDGES, CAPS, VENEERS AND BONDING

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily, and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces, and may require modification of daily cleaning procedures.

#### 8. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me, including looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

#### 9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment.

#### 10. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand that the success of any treatment plan depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations.

*I understand that dentistry is not an exact science, and therefore, that reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist, other than the treating Dentist is responsible for my dental treatment. I acknowledge the receipt of, and understand postoperative instructions, and have been given an appointment date to return.*

Name (printed): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Acknowledgement of Notice of Privacy Practices

This form will be retained in your medical record.

By my signature below, I \_\_\_\_\_, acknowledge that I **received** a copy of the Notice of Privacy Practices for Essence of Dentistry.

I hereby designate the following individual(s) to receive communications from Essence of Dentistry that may include health information about me:

\_\_\_\_\_

\_\_\_\_\_  
Signature of patient (or legal representative)

\_\_\_\_\_  
Date

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### For Office Use Only

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I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- In an emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date

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## Office Payment, Appointments and Insurance Policy

We strive to provide excellent care, skill and judgment and in return, we ask for your help in paying for our services in a responsible and timely manner. Please feel free to ask any questions regarding this policy.

1. **CONTRACTED INSURANCE:** All contracted insurance companies are billed directly as a courtesy. We require that the deductible, co-payments and non-covered benefits be paid for on the day services are rendered. In general, benefits should be assigned to us. Insurance policies do not guarantee any payments. The payment toward any charges may vary. Any remaining balance following insurance payments are your responsibility. Payment for this is expected within 30 days from receipt of your statement.
2. **CO-PAYS:** All co-pays are expected at the time the service is rendered.
3. **NON-CONTRACTED INSURANCE:** All Third Party Payers (motor vehicle accident insurance, commercial merchants, lawyers) are considered non-contracted.
4. **METHOD OF PAYMENT:** We accept cash, checks, VISA or MasterCard and Discover. 5% discount is applied if payment by cash or check is received before treatment day for all amounts that are \$500.00 and above.
5. **PAYMENT ARRANGEMENTS:** We understand that there may be times when financial difficulties come upon us without warning. Under special circumstances temporary payment arrangements may be made if approved in advance. Accounts on a temporary payment plan are required to make payment each and every month. Missed payments could result in collections. Accounts on a payment plan also must continue to pay at the time of service. Our goal is to help you from attaining a greater debt and to assist you by keeping your account at a manageable level.
6. **RETURNED CHECKS:** There will be a \$ 25.00 charge for all returned checks.
7. **SERVICE FEE:** There is an interest fee accrued on ALL accounts (up to 12% per annum) with balances 60 days and over, regardless of payment arrangements or secondary insurance status. Should the account be forwarded to collection, you will be responsible for all related collection fees and interest added to your account.
8. **DIVORCED, SEPARATED, OR BLENDED FAMILIES:** Essence of Dentistry's role is to serve as your oral health care provider and to provide the best possible care. In order to keep our accounts clean and eliminate any embarrassing or uncomfortable situations for your, we have chosen NOT to become involved in any agreement, understanding, and/or court order regarding reimbursement from the absent parent is your responsibility.
9. **NO SHOW/CANCELLATION POLICY:** There may be a \$75.00 PER HOUR fee for no-show appointments or cancellation of appointments without 48-hour notice.
10. **DUPLICATION OF CHART & X-RAYS:** There is a reasonable \$15 fee for searching record service. A \$0.65 per duplicated page for the first thirty pages and 0.50\$ per page for all other pages. .

*I understand that the doctor's office will aid in submitting claims to my insurance company on my behalf. I also understand that I have the final responsibility for payment of all fees for services rendered on my behalf. Unless otherwise noted, I authorize payment of dental benefits to the doctor for services provided to me or any member of my family covered under my insurance plan.*

**I HAVE FULLY READ, UNDERSTAND, AND CONSENT TO ALL OF THE ABOVE TERMS.**

Signed: \_\_\_\_\_ Front Office Coordinator \_\_\_\_\_

(Patient, parent or guardian who is financially responsible for account.) Date: \_\_\_\_\_