HARTFORD FAMILY DENTISTRY

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT FOR RECEIPT OF INFORMATION

State law requires that we obtain consent for the contemplated dental treatment. What you are being asked to read and sign is confirmation that we have discussed the nature and purpose of your planned treatment and the potential risks that are associated with said treatment. Please ask us about anything you do not understand any member of our team will be happy to explain. This should also include any necessary or advisable anesthesia.

ALTERNATIVES TO THE RECOMMENDED DENTAL TREATMENT:

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

RISKS ASSOCIATED WITH RECOMMENDED DENTAL TREATMENT:

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 associated anesthetic are listed below:

- Change of bite
- Loss of taste
- Drug/allergic reaction
- Dry socket
- Infection
- Fractured/broken root(s)
- Retained root fragments
- Loss/damage to adjacent teeth & bone
- Fractured or broken jaw
- Sinus involvement
- Further surgery or treatment
- Pain
- Broken instruments
- Swelling & bruising
- Retained instrument fragment(s)
- Paresthesia
  (permanent or transient numbness of the cheeks, gums, teeth, lips, tongue, chin & face)
- Stretching of the skin that may result in cracking & 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
- Swallowing/Inhaling objects
- Trismus
  (pain in the jaw leading to difficulty opening)

State law requires that we specifically advise you, although rarely occurring, dental treatment with anesthetic may result in: death, brain damage, quadriplegia, paraplegia, organ(s) loss; loss of facial, arm(s) & leg(s) function & disfiguring scars.

PLEASE SEE NEXT PAGE TO SIGN THIS ACKNOWLEDGEMENT

ACKNOWLEDGEMENT

I acknowledge I have received and understand the information on both pages of this consent form or it has been clearly read reviewed with 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 have 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 depend, to an extent, upon my compliance with oral hygiene, personal habit restrictions, and dietary restrictions that have been explained to me. I further understand keeping the appointments for follow up are also extremely important. Lastly, I understand I am to notify the dentist immediately with ANY suspected complications as further treatment may be discussed/administered that was not initially anticipated.

I hereby authorize and direct **Kirby L. Hart, III, D.M.D**., his assistants, or associate of his choice to perform the diagnostic, surgical or dental treatments. This consent form will remain valid until revoked by me, the patient, in writing. All blanks were completed prior to my signature. I waive any further disclosures or information.

DATE: _____

Signature of PATIENT: _____

Signature of PARENT/GUARDIAN: _____

Signature of WITNESS: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

A copy of this office's Notice of Privacy Practices was made available to me,

_____.

PLEASE PRINT NAME

_____

SIGNATURE

_____

DATE

_____

For Office Use Only

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

- The individual refused to sign.
- Communications barriers prohibited this office from obtaining acknowledgement.
- An emergency situation prevented acknowledgement from being obtained.
- Other (Please Specify)

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_____

PATIENT AGREEMENT

Please initial and sign.

_____As a courtesy to our patients using insurance, we are happy to file claims on your behalf. 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 Hartford Family Dentistry, the patient will be responsible for all incurred charges.**

_____Hartford Family Dentistry provides the most up-to-date services. These services include, but are not limited to, composite (tooth-colored) fillings, restorative cosmetic dentistry, and implant 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 60 minutes in length or more will require prepayment prior to scheduling.**

_____After 90 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 first scheduled exam. If our dental insurance does not cover this procedure, the patient will be billed $24.00.**

_____Although fluoride treatments for ADULTS are not usually a covered benefit of most dental insurance policies, they are proven to protect our teeth against new decay by 75%; we strongly recommend for ALL patients. If your dental insurance does not cover this procedure, the patient will be billed $24.00.

_____**I authorize and give consent to Hartford Family Dentistry 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.**

_____Because time for all of us is valuable, we ask for a MINIMUM 24 hour notice for any appointment cancellations or reschedules. Please understand the appointment reserved especially for you is difficult at best to fill if not given adequate time to do so. Our team does a great job in reaching out with courtesy appointment reminders. However, if we are unable to confirm the appointment with you we will be left with no other option but to cancel the appointment and offer to another patient who may need our care.

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, and the cost of collection proceedings. I also waive the right to have any amounts owed discharged in bankruptcy.

Date: _____ **Signature:** _____

AUTHORIZATION AND RELEASE

I, _____ do hereby release 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, I hereby release them from any and all liability arising from such disclosures.

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____

YOUR DENTAL INSURANCE IS A PERSONAL 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 the assignment of benefit payments from most insurance companies. This will reduce your immediate out-of-pocket expenditures. Our estimate is based on limited information obtained from your insurance company. We will allow 45 days for your insurance company to make payment. AFTER THIS TIME, ALL FOLLOW UP ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

Signature: _____ Date: _____