



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

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

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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)

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 \$49.00.**

_____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 \$38.00.

_____ **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: _____



Because we think saying “thank you” is really important, we would like to know how you found our office. Please check all that apply.

- Facebook
- Internet/Website
- Out front signage
- Neighborhood Newsletter (Flyer)
- T.V. Commercial
- Radio
- Yellow Pages
- Family/Friend: _____
(Please list who we can thank.)
- Other: _____
(Please specify)

Please understand if you incur an unpaid balance and do not make satisfactory payment arrangements, your account may be placed with an external collection agency. You will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses acquired in collecting the balance due, and possibly including reasonable attorney’s fees if so accrued during collection efforts.

SIGNED: _____ DATE: _____



What is your primary concern you'd like us to address today?

When it comes to your oral health, do you prefer to be Proactive? Someone who likes to avoid complications. Who'd rather take care of an issue today instead of letting it worsen over time which might cost more time, visits, money and/or pain to fix it down the road?

YES NO

Do you consider yourself more of a reactive person – someone who would rather wait to deal with any issues after they develop, even if that means costing you more time, visits, money, and/or pain or fix down the road?

YES NO

Do you have a high dental anxiety or fear when visiting the dental office for treatment? Would you like us to discuss sedation options that can keep you as comfortable as you'd like to be but also make you remember as little about your visit as you want?

YES NO

Do you prefer to pay your bill in full or would you rather look at breaking your bill out into monthly payments over time, either at a low interest or 0% interest rate?

What do you value most in a dental office? **Please Circle and write answer below on line.**

Cosmetic- You most value how your teeth look. Want them straight. Want them white.

Function- You most value an ability to enjoy your favorite foods and drinks. Don't want to be limited to just eating on one side or area. No food or drink should be off limits to you.

Comfort- You most value NOT being in pain or having any tooth or gum sensitivities. Example: I can't eat this anymore because it hurts or is sensitive.

Longevity- You most value the ability to have your natural teeth forever. You wish to have the work you have done in the chair to last as long as possible.

What is the most important objection or obstacle you have to visiting a dental office? **Please circle write answer below on line.**

No objections or obstacles- I come faithfully every 6 months and value my dental health. No fear of pain, noises, environment, or past experiences.

Time- Getting appointments to suit your schedule. Not able to take off of work, ect. Getting in and out of office quickly.

Have NOT had a sense of urgency- Nothing really hurts so haven't seen need to go to dentist in years or something has been hurting at some level for a while but I've been able to live with it.

Budget- Knew I needed a lot of work, didn't have money to address any issue found.

No Trust- Felt you were told you needed treatment you didn't need. Felt ripped off. Bad previous experience. Didn't give me any data to support treatment they recommended.

Do you prefer to pay off your balances over time or pay them in full so nothing is owed?

Do you prefer to break your appointments up into smaller visits and schedule out over time?

Do you prefer to get any necessary treatment done today, if possible, as getting into the office is a challenge for you?
