Patient Consent and Acknowledgement

HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and referrals.

Our notice provides a description of our treatment, payment activities and healthcare operations. In addition, it provides the uses and disclosures we may make of your protected health information. Your signature below is also your consent to treatment at Dental Arts of Corinth, PLLC.

I understand that I may revoke this consent in writing at any time.

_____ specifically has my written consent to call and make appointments, discuss treatment plans and account balances. (This is anyone close to you that you wish to have this information.)

_____ _____ _____

Patient/Guardian Signature: Date: Relationship to Patient:

Phone: (662) 287 - 3156
Fax: (662) 287 - 3157
1025 Foote Street Corinth, MS 38834

DENTAL ARTS of CORINTH, PLLC

Informed Consent to Perform Dentistry

I hereby authorize and direct the dentists of Dental Arts of Corinth, PLLC to perform the following dental and/or orthodontal treatments, oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs, and/or diagnostic aids. These treatments and/or procedures include, but are not limited to examinations, oral prophylaxes (cleanings), fluoride applications, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) procedures, and extractions.

I understand that there are risks involved in these treatments and hereby acknowledge that the risks have been explained to me, that I have had an opportunity to ask questions regarding the treatments and their risks, and that I fully understand those risks.

I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia, depending on the judgement of the doctors.

My treatment options have been explained to me. Alternate methods of treatment, if any, have been explained to me, as have the advantages, disadvantages, and risks of each. I am advised that though positive results are expected, the possibility and nature of complications cannot be accurately anticipated.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performance of any additional procedures that are deemed necessary or desirable.

I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia, sedation and medications. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma, (swelling or bleeding at or near the injection site), fainting, lip and cheek biting, resulting in ulceration and infection of the mucosa.

_____ _____ _____

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DENTAL ARTS of CORINTH, PLLC

Dental Insurance Coverage Notice and Disclaimer

I understand and agree that if this dental office does not participate with my dental insurance plan, this office cannot make any representation or guarantee that my insurance company will cover all or any portion of my dental services provided by this office.

I further understand that I will be billed and responsible to pay for any and all amounts not paid by my dental insurance.

I realize that such bills will include amounts incurred from deductibles, co-payments, co-insurance, and amounts not paid by my insurer, due to exhaustion of benefits or non-covered services.

I acknowledge and understand that it is my ultimate and sole responsibility to determine whether a dental service, procedure, or treatment plan is covered by dental insurer. **All quotes are "ESTIMATES ONLY".** I understand actual benefits will be determined by my dental insurer once my claim is submitted for payment.

I acknowledge and understand that this office will not, as a matter of policy, agree to halt any service, procedure, or treatment plan solely because my dental insurance benefits have exhausted, and I certainly understand that this office cannot know at what point in my treatment insurance benefits will exhaust.

I confirm that no representation has been made to me by anyone in this office that is contrary in any way to the above notice and disclaimer.

I confirm that any statement made by anyone in this office concerning my dental coverage cannot be relied upon as a guarantee of coverage or payment.

I acknowledge that I am responsible for knowing my specific dental benefits and dental network provisions. I understand I am financially responsible for all charges for my dependents or myself, whether or not they are covered by my insurance. In the event this account is submitted for collections, I, the undersigned agree to pay any and all collection costs and reasonable attorney fees, as well as, the full outstanding balance of charges originally placed with a collection agent.

***SPECIAL NOTICE*: I UNDERSTAND THAT IF I DO NOT SHOW UP FOR MY APPOINTMENT, OR CANCEL AT LEAST 2 BUSINESS DAYS BEFORE MY APPOINTMENT, A CANCELLATION/NO-SHOW FEE OF $25 WILL BE ADDED TO MY BALANCE.**

I, the undersigned, agree to all of the terms stated and promise to pay accordingly.

_____ _____

PRINT NAME: **Date:**

_____ _____

Patient/Responsible Party Signature: **Date:**

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1025 Foote Street Corinth, MS 38834

Minor Request and Consent

(To be completed by parent or legal guardian)

I hereby authorize the following person(s) to bring my minor child, _____ for treatment and examination by the staff of Dental Arts of Corinth, PLLC. This consent will remain in effect from this date forward unless written revocation of such is duly presented to the office of Dental Arts of Corinth, PLLC by myself or a legally authorized representative.

1._____

2._____

3._____

4._____

5._____

I understand that it is my responsibility to:

- Provide accurate, updated medical history information in advance of my child's appointment.
- Remain accessible by phone during scheduled appointments.
- If treatment needs are determined at hygiene appointments, I will need to provide consent and treatment plan signatures prior to the operative appointment.
- Notify Dental Arts of Corinth, PLLC whether or not my child should receive fluoride or x-rays for their hygiene appointments.

_____ _____ _____

Patient/Guardian Signature: Date: Relationship to Patient:

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DENTAL ARTS of CORINTH, PLLC

Payment Policy and Agreement

We appreciate your selection of our office to serve your dental health needs. To avoid misunderstanding concerning payment of accounts, please note that PAYMENT IN FULL is required for ALL dental treatment. We will be happy to file insurance claims for you at no extra charge. In addition, you must provide our office staff proper instruction-insurance card, social security number and date of birth of the person you are filing insurance under. The ESTIMATED difference that the insurance does not pay is your responsibility and must be paid the day of each visit.

Your insurance is a contract between you, as a subscriber and/or beneficiary, and the insurance company, involving our office, Dental Arts of Corinth, PLLC, only indirectly. Therefore, any controversy which might arise over your insurance company's handling of your claim is your responsibility to resolve. Any insurance claim that has not been paid with 45 days of treatment will be billed to you for payment. We are a PPO provider for a select few insurance companies. Please be familiar with your policy. These stipulations also apply to all CHIPS and any other government sponsored insurance recipients.

A quote of expected payment by your insurance does not guarantee payment from your insurance company in that amount; we can only provide an ESTIMATE. You will be mailed a statement after each visit with a final balance. ***ANY ACCOUNT THAT HAS NOT BEEN PAID WITHIN 30 DAYS WILL BE CHARGED A MONTHLY LATE FEE OF $10. ACCOUNTS OVER 90 DAYS WILL BE SENT TO COLLECTIONS AND/OR ATTORNEY.**

( ) I have dental insurance and will pay my portion today.

( ) I do not have dental insurance and will pay in full.

I hereby assign, transfer, and set over to Dental Arts of Corinth, all rights, title and interest to my dental reimbursement benefits under my insurance policy. I authorize the release of any dental information needed to determine these benefits.

This agreement affects all services and charges present and future; and the authorization shall remain valid until written notice is given by me revoking said authorization.

I authorize the verification of my employment by this office or in the event my account becomes delinquent, by any collection agency or law firm to which my account is referred.

I understand I am financially responsible for all charges for my dependents or myself, whether or not they are covered by my insurance. In the event this account is submitted for collections, I, the undersigned agree to pay any and all collection costs and reasonable attorney fees, as well as, the full outstanding balance of charges originally placed with a collection agent.

***SPECIAL NOTICE*: I UNDERSTAND THAT IF I DO NOT SHOW UP FOR MY APPOINTMENT OR CANCEL AT LEAST 2 BUSINESS DAYS BEFORE MY APPOINTMENT, A CANCELLATION/NO-SHOW FEE OF $25 WILL BE ADDED TO MY BALANCE.**

I, the undersigned, agree to all of the terms stated and promise to pay accordingly.

Guarantor Signature: _____ Date: _____

Co-Guarantor Signature: _____ Date: _____

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