COVID-19 Pandemic Emergency Dental Treatment Consent Form

I,_____, have been fully informed of the need to undergo urgent, non-elective and potentially emergent dental treatment as presented to me on the date stated below. All of the details of such treatment and alternatives have been explained to me. I hereby knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus potentially has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has COVID-19 and who does not given the current limits in virus testing.

Dental procedures may create water spray which is one way in which the disease may be spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which may prolong the time in which it may transmit the COVID-19 virus.

- I understand that while my Provider may take the necessary precautions to reduce the risk of transmission of COVID-19 during any dental treatment and/or procedure, at this time due to presence of other dental patients, the nature and characteristics of the virus, and the nature and methods of dental procedures, there is no way to guaranty any procedure and/or treatment will be completely risk free. I hereby acknowledge that I may have an elevated risk of contracting the COVID-19 virus by being in a dental office. _____(Initial)
- I have been made aware that the CDC and ADA current guidelines do not recommend any non-urgent dental care be treated at this time. The CDC and ADA recommend that dental visits be limited to those necessary for the treatment of pain, infection, or other conditions that may significantly inhibit normal operation of teeth or mouth; as well as any other issues which may cause any of the above listed symptoms within the next 3-6 months. I confirm I am seeking treatment for a condition that meets these criteria. _____(Initial)

I confirm that I do not have any of the following symptoms: Fever, Shortness of Breath ,Dry Cough, Runny Nose, Sore Throat. _____ (Initial)

I understand that the CDC recommends social distancing of at least 6 feet. This is not possible with dentistry. _____(Initial)

I understand that air and other forms of commercial travel may significantly increase my risk of contracting and transmitting the COVID-19 virus. I verify that I have not traveled internationally or domestically by commercial airline, bus, or train within the past 14 days. _____(Initial)

I hereby knowingly and freely acknowledge, and assume any and all risks, known and unknown, related to the potential contraction of COVID-19 during the dental procedure and/or treatment, and assume full responsibility for such risk. I hereby agree to indemnify and hold harmless the Provider, its employees, officers, owners, doctors, directors, members, managers, members, contractors, agents and/or representative from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, which may be brought as a result of the dental procedures and/or treatment provided on the date identified below or hereafter as such treatment and/or procedure may be related to the contraction of COVID-19. _____ (Initial)

The undersigned, on behalf of myself as well as any of my heirs, personal representative or assign, hereby release, waive, discharge, and covenant not to sue the Provider, or any of the Provider's employees, officers, owners, doctors, directors, members, managers, contractors, agents, and/or representatives for any and all claims, known or unknown, which may be related to the transmission and/or contraction of COVID-19, including but not limited to claims which may result in personal injury, illnesses (including death), loss of income or other property loss. _____ (Initial)

Name_____ Date_____

COVID-19 Pandemic Emergency Dental Treatment Consent Form

I,_____, have been fully informed of the need to undergo urgent, non-elective and potentially emergent dental treatment as presented to me on the date stated below. All of the details of the recommended treatment and alternatives have been explained to me. I hereby knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic.

I have been made aware of the Center for Disease Control guidelines, the recommendations of the American Dental Association, and Local/State Public Health Mandates all state that any non-urgent dental care is not recommended. At this time, dental visits should be limited to those necessary for the treatment of pain, infection, or other conditions that may significantly inhibit normal operation of teeth or the mouth; as well as any other issues which may cause any of the above listed symptoms within the next 3-6 months. I understand that some dental infections, if left untreated, can lead to serious complications, including the need for hospitalization.

_____ I confirm I am seeking treatment for a condition that meets these criteria

Procedure Issues

_____ I understand that the treatment provided by my dentist may only be intended to eliminate or reduce the infection and/or pain that I am currently experiencing and may not be definitive care. There may be a need for additional procedures to return the state of my mouth to optimum health. Failure to seek additional treatment that my doctor recommends may result in further issues, including pain, infection and loss of teeth/ bone and/or function.

_____Due to the extreme nature of this pandemic, I understand that post-treatment monitoring may be more challenging as additional in-office visits are not recommended. I understand and agree, to the extent that it may be appropriate, that my doctor may opt to perform post-operative monitoring remotely. I agree to participate in remote patient monitoring, if my doctor determines it to be necessary and follow all post-treatment instructions.

_____After my procedure, I understand that I may be at higher risk for further infection and more susceptible to the COVID-19 virus. I agree to remain at home in compliance with the state "Safer at Home" mandates and adhere to all safety recommendations by the CDC.

_____ I understand that to mitigate certain risks, it is imperative that I take any medications which may be prescribed. I further understand that certain medications, such as opioid "pain" medications, cannot be called into pharmacies.

Unique Circumstances

_____Dental procedures may create a water spray (aerosol), which is one method in which the disease may be spread. The ultra- fine nature of the spray may linger in the air for minutes to sometimes hours, which can increase the time period in which the COVID-19 virus may be transmitted.

_____I understand the COVID-19 virus potentially has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who may have COVID-19 and who does not given the current limits in virus testing.

_____I understand that while my Provider may take the necessary precautions to reduce the risk of transmission of COVID-19 during any dental treatment and/or procedure, at this time due to presence of other dental patients, the nature and characteristics of the virus, and the nature and methods of dental procedures,

there is no way to guaranty any procedure and/or treatment will be completely risk free. I hereby acknowledge that I may have an elevated risk of contracting the COVID-19 virus by being in a dental office.

_____ I confirm that I do not currently have, nor have I had in the last 14 days, any of the following symptoms of COVOID-19: fever, shortness of breath, dry cough, runny nose, sore throat.

_____I confirm that I have not been in contact with a person that has been diagnosed with COVID- 19 within the last 14 days.

_____ I understand that the CDC recommends social distancing of at least 6 feet to prevent transmission of disease and this is not possible with dentistry.

_____I agree that, if I were to exhibit any symptoms of, or am diagnosed with, COVID-19, I will immediately contact my dentist so that proper steps can be taken to limit the spread of this contagion.

_____I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be completely successful in resolving my pain and/or infection. It is anticipated that the treatment will provide benefit in reducing the cause of this condition. However, due to individual patient differences and the extenuating circumstances, there exists a risk of failure relapse, selective retreatment, or worsening of my present condition, including the loss of additional teeth/bone, despite the best care.

_____I hereby knowingly and freely acknowledge, and assume any and all risks, known and unknown, related to the potential contraction of COVID-19 during the dental procedure and/or treatment, and assume full responsibility for such risk. I hereby agree to indemnify and hold harmless the Provider, its employees, officers, owners, doctors, directors, members, managers, members, contractors, agents and/or representative from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, which may be brought as a result of the dental procedures and/or treatment provided on the date identified below or hereafter as such treatment and/or procedure may be related to the contraction of COVID-19.

_____The undersigned, on behalf of myself as well as any of my heirs, personal representative or assign, hereby release, waive, discharge, and covenant not to sue the Provider, or any of the Provider's employees, officers, owners, doctors, directors, members, managers, contractors, agents, and/or representatives for any and all claims, known or unknown, which may be related to the transmission and/or contraction of COVID-19, including but not limited to claims which may result in personal injury, illnesses (including death), loss of income or other property loss.

I have read, comprehend, and agree with the above statements.

Name_____ Date_____

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home _____ Work _____ Cell _____

E-Mail _____ Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work/Cell Phone _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Check "Yes" or "No" where indicated for all that apply:

Would you like whiter teeth?	❑ Yes	❑ No	Burning sensation on tongue	❑ Yes	❑ No	Loose teeth or broken filings	❑ Yes	❑ No
Bad breath	❑ Yes	❑ No	Chew on one side of mouth	❑ Yes	❑ No	Mouth breathing	❑ Yes	❑ No
Bleeding gums	❑ Yes	❑ No	Cigarette, pipe, or cigar smoking	❑ Yes	❑ No	Mouth pain, brushing	❑ Yes	❑ No
Blisters on lips or mouth	❑ Yes	❑ No	Clicking or popping jaw	❑ Yes	❑ No	Orthodontic treatment	❑ Yes	❑ No
			Dry mouth	❑ Yes	❑ No	Pain around ear	❑ Yes	❑ No
			Fingernail biting	❑ Yes	❑ No	Periodontal treatment	❑ Yes	❑ No
			Food collection between the teeth	❑ Yes	❑ No	Sensitivity to cold	❑ Yes	❑ No
			Foreign objects	❑ Yes	❑ No	Sensitivity to heat	❑ Yes	❑ No
			Grinding teeth	❑ Yes	❑ No	Sensitivity to sweets	❑ Yes	❑ No
			Gums swollen or tender	❑ Yes	❑ No	Sensitivity when biting	❑ Yes	❑ No
			Jaw Pain or tiredness	❑ Yes	❑ No	Sores or growths in mouth	❑ Yes	❑ No
			Lip or cheek biting	❑ Yes	❑ No			

How often to you floss? _____

How often do you brush? _____

– OVER –

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Alzheimers	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Fainting or dizziness	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	Hepatitis (Type _____)	❑ Yes	❑ No	Skin Rash	❑ Yes	❑ No
Bleeding abnormally, with extraction or surgery	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
			High Blood Pressure	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	HIV Positive	❑ Yes	❑ No	Swelling of Feet or Ankles	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	Jaw Pain	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Tumor or growth on head or neck	❑ Yes	❑ No
Cortisone Treatments	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No			
Cough, persistent or bloody	❑ Yes	❑ No	Nervous Problems	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No

WOMEN: Are you: **Pregnant?** ❑ Yes, _____ Months ❑ No **Nursing?** ❑ Yes ❑ No **Taking birth control pills?** ❑ Yes ❑ No

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin
❑ Barbiturates (Sleeping pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other _____

X _____
SIGNATURE OF PATIENT OR PARENT OF MINOR

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Kennesaw, Ga 30144
678-275-2066
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Dentistry AT KENNESAW POINT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;

- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials, for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we

do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices.

Responsible Party
Signature_____Date_____

Relationship to Patient_____

FINANCIAL POLICY & AGREEMENT

Thank you for allowing us to be your dental care provider. We are committed to providing the highest quality of dental care to all of our patients. The prompt payment of your treatment fees allows us to continue providing the highest quality of care. In the pursuit of these goals, we have established the following financial policy:

ESTIMATES We will give you a cost estimate before treatment is rendered. We will try to insure that the cost estimate is complete and accurate; however, there are circumstances when it becomes impossible to know exactly what treatment needs to be performed. Sometimes the dental condition requires less treatment, in which case your treatment fees will be less than estimated. Other times, the dental condition requires more treatment than initially anticipated, in which case your treatment fees will be more than estimated. If more treatment is required than initially estimated, you will be informed of the treatment required and fees before the additional treatment is performed.

PAYMENT DUE Full payment of the fees is due at the time of service. We accept cash, check (drawn on a local bank), VISA, MasterCard and Discover. Treatment, which requires more than two hours of appointment time, will require payment in full five business days prior to the appointment. Appointments will automatically be cancelled if payment is not received.

PAYMENT PLANS Payment plans are available through Care Credit, and Capital One. Interest free plans are available to qualified individuals. Care Credit, Capital One. NOT this office determines who may qualify and the amount of credit available.

BROKEN APPOINTMENTS We require 48 hours notice to cancel or reschedule an appointment. There will be a per-hour fee assessed for failure to provide 48 hours notice to cancel or reschedule an appointment. Not to Exceed 100.00 per visit.

AFTER-HOUR EMERGENCY CARE We provide after-hours emergency care for established patients only. This emergency is for "true emergencies" determined only upon the doctor's discretion.

INSURANCE Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full. If you have any questions, our courteous staff is always available to answer them. **There are no grace periods. No refunds.** There will be no exceptions. If the terms of this agreement are defaulted upon we reserve the right and will collect the balance in full. Any legal fees or cost to collect this debt will be paid by the patient.

Fee For Service Practice.
If we are a participating provider for your dental insurance, we will file your insurance claim for you. We will estimate your insurance benefit and you will be required to pay the estimated balance at the time of treatment. Since the insurance benefit is an estimate only, you will be required to pay any amount still due after your insurance company pays on the claim. If there is a credit on your account after the insurance payment, this amount will be refunded to you or remain as a credit on your account for future treatment, as your choice. The **OFFICE INSURANCE POLICY AND ASSIGNMENT OF BENEFITS** is made a part of this **Financial Policy & Agreement**.

COLLECTION OF PAST DUE ACCOUNTS

Accounts that are not paid according to this **Financial Policy & Agreement** may be turned over to an independent collection agency. In the event that your account is turned over for collection, you will be responsible for all fees incurred in the collection of your account.

RETURNED CHECKS

Any checks returned due to insufficient funds must be paid within five business days and will incur a $35 returned check fee. Returned checks not paid in full (including the returned check fee) within five days will incur a 15%per month interest charge and the account may be turned over for collection. Any checks returned for being written on a closed account will be forwarded to the State Attorney and the account immediately sent to collection.

I, _____, have read, understand, and agree to abide by this **Financial Policy & Agreement.** (Print Name of Responsible Party)

Responsible Party Signature_____Date_____

Relationship to Patient_____

Dentistry at KENNESAW POINT

Kay Kalantari, D.D.S.

PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____