Plantation Dental Studio & Implant Center PLLC
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

PATIENT GIVING CONSENT

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You will have the right to revoke this consent by giving us written notice of your revocation submitted to Aesthetic Dentistry of Plantation, 1411 South University Drive, Plantation, Florida 33324. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE: I, _____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____ _____

Signature of Patient / Parent or Guardian (If minor) Date

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Plantation Dental Studio & Implant Center PLLC

I. INFORMED DENTAL CONSENT-You have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following: pain, swelling, and discomfort after treatment, allergic reaction to anesthetic or medication, temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste, an altered bite in need of adjustment, and/or infection in need of medication, follow-up procedures or other treatment.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks and complications or recommended treatment with your dentist. Be certain all your concerns have been addressed to your satisfaction by your dentist before commencing treatment

I have read and understand Informed Dental Consent and consent to dental treatments.

_____ _____

Initials Date

II. FINANCIAL POLICY- Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. Our fees are based on the quality materials we use, and the time, effort and skill required in performing your needed treatment. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health.

1. Patients WITH Insurance Coverage:
Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefit from your insurance carrier as a courtesy to you. However, you are responsible for the payments of your account. We can request a pre-estimate of benefits from your insurance company if you request to do so. Routine treatments are generally performed without submitting a request for a pre-estimate of benefits. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due **PRIOR TO TREATMENT**. If your insurance company has not paid the claim within 45 days, the balance will be automatically transferred to you. In some cases, insurance carriers may pay for alternative benefits other than the treatment performed. In this case, you are responsible for paying the difference. As a courtesy, if you have dual coverage dental insurance (coverage from insurance carriers), we can submit the claim on your behalf to the secondary carrier and the insurance carrier will reimburse you directly.

THE BALANCE FOR SERVICES RENDERED MUST BE PAID BEFORE FINAL INSERTION. If you are having extensive treatment over an extended period of time, we request scheduled payments during the course of treatment. Our financial coordinator will assist you in arranging a financial arrangement.

2. Patients WITHOUT Insurance Coverage:
Patients without insurance coverage are required to pay for services at the time of services rendered. We accept many forms of payment including cash, MasterCard, Visa, American Express, Discover, and Debit/ATM cards.

III. BILLING POLICY-Payment for services is due at the time services are rendered unless prior arrangements have been made.
1. Checks returned unpaid from the bank are subject to a $35.00 service fee.
2. Accounts delinquent more than 45 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to our collection agency you will be responsible for collection and court costs along with the attorney's fees.

IV. MISSED APPOINTMENTS/CHANGE IN SCHEDULE POLICY-Our practice is dedicated to quality care and exceptional service. Our doctor and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients. If you find that you must change or cancel your appointment, we require a minimum of 48 hours' notice so that we may make every effort to accommodate other patients.

If proper notice is not received, a fee of $50.00 will be charged for every hour of appointment time.

_____ _____

Initials Date

We welcome you to our office and want to provide you with the best care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

I HAVE READ AND UNDERSTAND Plantation Dental Studio & Implant Center PLLC INFORMED CONSENT, FINANCIAL POLICY, BILLING POLICY, AND SCHEDULING POLICY.

_____ _____

Signature of Patient / Parent or Guardian (If minor) Date

_____

Witness