West Meade Dental

Dr. Allison Kisner

DENTAL CONSENT AGREEMENT

1) **CONSENT TO TREATMENT & OUTCOMES:** I consent to receive dental services from West Meade Dental. I understand that the initial visit may require radiographs to complete the examination, diagnosis and treatment plan. I understand I will be provided a treatment plan for necessary services. I understand that the practice and Dr. Kisner cannot guarantee treatment outcomes. I am responsible for reviewing the treatment plan and asking any questions I may have prior to receiving treatment. I have the right to accept or reject treatment recommended by Dr. Kisner. By consenting to Dr. Kisner's treatment plans, I acknowledge that I accept known risks and complications of such treatments. However, I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give permission to Dr. Kisner to make changes and additions as necessary and appropriate. I will be informed of these changes before treatment is completed.

   It is my responsibility to fully inform Dr. Kisner of my medical history, all medications or other drugs that I am using and otherwise truthfully answer all questions related to my care. It is my responsibility to follow Dr. Kisner's pre- and post-treatment instructions and oral care instructions. I acknowledge that failure to comply with these requirements may increase the chance of poor treatment outcomes.

2) **PAYMENT FOR SERVICES:** I understand that I am responsible for all charges for the care I receive. If I do not have dental insurance coverage, I will pay all amounts for which I am responsible in full, in advance of treatment.

   It is my responsibility to provide accurate and up-to-date information regarding my dental insurance coverage. I understand that my dental insurance policy is a contract between me and my insurance company. I understand that I will be responsible for any deductibles, copayments, costs of uncovered services, and any other part of the bill that my dental plan says I must pay.

   West Meade Dental will submit all dental insurance claims on my behalf as a courtesy. West Meade Dental emphasizes that our relationship is with you, and not your insurance company. The practice will make every reasonable effort to help you maximize the dental benefits that you have already paid for. West Meade Dental will be available to discuss your estimated insurance coverage, your estimated cost, annual maximum and deductible.

   If for any reason I do not pay, in full, the amounts I owe the practice, I will also reimburse the practice for all costs of collection, including legal fees and collection agency fees. I also agree the practice may charge me interest, equal to 1.5% monthly, on all balances that have been outstanding for thirty (30) days or more.

3) **CONSENT TO PHOTOGRAPH:** I understand photographs may be made for identification and for treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my images.

4) **SCHEDULING AND APPOINTMENTS:** I understand that it is my responsibility to change or cancel my appointments I can no longer make ***at least*** 24 hours prior to the scheduled appointment. If I do not do so, West Meade Dental may charge me a cancellation fee of up to $50 per scheduled half hour.

5) **DISCLOSURES TO FAMILY AND FRIENDS:** I give permission for my health information, including billing and treatment records, to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below:

Name	Relationship	Phone Number

I may revoke or modify this specific authorization in writing at any time. In addition, if anyone has the legal right to act on my behalf (such as the parent of a minor or court-appointed guardian), I understand that you may share health information with them regardless of whether I have identified them above.

6) **COMMUNICATION CONSENT:** I agree, that unless I tell you otherwise, when I provide my landline or cell phone number(s), I am giving you consent to contact me at these numbers, or at any number that is later acquired for me and to leave messages to voicemail or text, regarding scheduling or scheduled appointments, services, or my bill.

Unless I decline to give consent below, I acknowledge I may be contacted via voicemail, text, or email.

1. _____ I decline to receive communication via text. (Initial please)
2. _____ I decline to receive communication via email. (Initial please)
3. _____ I decline to receive communication via voicemail. (Initial please)

7) **NOTIFICATION OF PRIVACY PRACTICES:** I acknowledge that I have been able to review the Notice of Privacy Practices as posted in the practice office. A printed copy was given to me if I so requested. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in West Meade Dental's Notice of Privacy Practices.

I agree to the items as outlined in the Agreement.

Name (Print): _____ Date: _____
Signature: _____
Relationship to Patient (Circle One): Self/Parent/Personal Representative