MEISTER DENTAL GROUP

General Consent for Treatment and local Anesthesia

While serious complications associated with dental procedures are very rare, we would like to be informative about necessary procedures in dentistry and your consent before beginning treatment. The following risks and or complications exist with dental treatments.

Complications resulting form the use of dental injections and anesthetics include and are not limited to:

- Swelling at site of injection.
- Bleeding at site of injection.
- Infection at site of injection.
- Discomfort at site of injection.
- Prolonged numbness and tingling sensation in oral cavity. These sensations are usually temporary but can be permanent.
- Jaw muscle cramps and spasms.
- Jaw joint discomfort or pain radiating to head, neck, and ear.
- Nausea and vomiting.
- Allergic reaction.
- Rapid or irregular heartbeat.
- Biting of check, lip and tongue after treatment resulting in swelling and discomfort.

Complications from medications or prescription medications given in office can be common, to decrease your risk of a potentially serious drug reaction. Please provide us with the knowledge of any past drug allergies or adverse reactions. In addition, we are careful about the medications we prescribe and will not prescribe and will not prescribe a medication unless necessary:

- Allergic reaction– Itching, Swelling or difficulty breathing
- Adverse reactions– Nausea, Vomiting, Headache, Drowsiness

Depending on the procedure, minor to moderate sensitivity of the teeth or soreness of the gums in the are that was treated is completely normal. If you have any questions or concerns after care, please do not hesitate to contact the office.

I have read and understand this form and give general informed consent of dental treatment.

_____ _____

Patient's Signature Date

Meister Dental Group

Assignment of Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office. We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.

Insurance payments ordinarily are received within 30-60 days form the time of billing. If your insurance company has not made a payment to our office within 60 days, we will ask you to pay the balance due at the time. You will be responsible for seeking reimbursement from your insurance company at the time.

Our office does not Guarantee that your insurance company will pay for treatment you receive from our practice/ We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at the time.

Our office will not enter a dispute with your insurance company over any claims, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may raise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made our not made by your insurance company

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL DIRECTLY TO THE DOCTOR.

_____ SIGNATURE OF PATIENT/RESPONSIBLE

ACKNOWLEDGEMENT OF PRIVACY PRACTICES PATIENT CONSENT FORM

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____Date:__________________

Signature: ________________________________Relationship to Patient _______________________

Dependent family members also covered by this acknowledgement:

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AUTHORIZATION TO RELEASE INFORMATION TO OTHER

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental condition and/or dental treatment disclosed to someone else indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

☐ You May Disclose My Information To The Following (indicate below):

☐ Do Not Disclose My Information to Anyone But Me

1. __________________________________ Relationship to Patient: ______________________ Date: ______

2. __________________________________ Relationship to Patient: ______________________ Date: ______

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- For Office Use Only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason: ____ The patient refused to sign ___Communication Barriers __ Emergency Situation __ Other

Financial Policy

Thank you for choosing our practice to serve your dental needs.
Please take the time to read the following, initial each section, and sign and date the bottom of this form.

_____Full co-payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____Some of your treatment may **not** be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____At Meister Dental Group we schedule your appointment so that the time is reserved for you. Therefore, we reserve the right to charge a $50.00 fee per broken appointment without a 24-hour notice of cancellation. This fee will be charged to compensate the time the doctor has spent in planning your treatment and the amount of time allotted for your appointment.

_____We do not double book our patients. Any appointments that are scheduled for TWO hours requires **a $50.00 deposit** when scheduling. The $50.00 is to hold the Doctor's chair time for you. The deposit goes towards treatment on day of service.

_____There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)

** Patient balances that go unpaid for r30 days or more may incur one or more of the following charges: ***Interest Charges of 1.5% per month 18% APR collections fees (up to 25% of the full balance) Legal fees for collection services***

_____ _____

Signature of Patient or Guardian Date

_____

Print Name