Melrose Family Dental, PC
12 Porter Street
Melrose, MA 02176

General Informed Consent for Dental Procedures

You, the patient, 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 of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
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.
Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be provided

I understand that during my course of treatment that the following care may be provided:

Examinations, Preventive Services, Diagnosis, Basic Restorative and Crowns:
Patient Initials: _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **Patient Initials:** _____

3. Changes in Treatment Plan

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, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
Patient Initials: _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. **Patient Initials**: _____

_____
Date

_____
Patient Signature **Date**

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FINANCIAL POLICY AGREEMENT

Thank you for choosing our office. Our primary mission is to deliver the highest quality and most comprehensive dental care available. In order to serve you better please adhere and be advised of our financial policy

- Payment is due in full at the time of service. We gladly accept cash, check, Visa, Discover and Master Card

Convenient monthly Payment plans are now offered through Care Credit. Care Credit is based upon credit approval

- **Dental Insurance In Network Financial Policy**:
  If you have dental Insurance that we are **In Network** with then, Deductibles and out of pocket expenses are due at the time of service. If there is any additional balance after the Insurance process then the balance is your responsibility.
- **Dental Insurance Out of Network Financial Policy**:
  We are happy to work with any **Out of Network Insurance Carriers** to maximize your benefits and bill them directly for reimbursement of your treatment. If we do not receive payment from your Insurance carrier **within 60 days**, you will be responsible for payment of your treatment fees and collection of your benefits directly from ins carrier. Billing Charges will be assessed if the bill isn't paid in a timely manner.
- Pre-determination and courtesy benefit checks are available to you upon requests so it can be determined what your financial responsibility is in conjunction to what your insurance will pay
- If an appointment is missed or cancelled on the same day of the appointment, then there will be a $79 charge assessed. We do allow a onetime courtesy and the fee will be waived.

Patient Name:

Patient Signature _____ Date_____

Witness _____Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 disclosures we may make of your protected health information, and of other important matters about your protected health information. Notice of Privacy Practices is attached and we encourage you to read it carefully and completely before signing this Consent

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

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Please list name:

Name: _____ Relation: _____

Patient Name:

Patient Signature: **Date:**

If this Consent form is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□□Individual refused to sign

□□Communications barriers prohibited obtaining the acknowledgement