Herron Regional
DENTAL CENTER

PATIENT NAME: _____ **DENTIST**:_____ **FILE #** _____

I understand that I may have one or more of the following done: General examination or Cleaning, Fillings, Bridges, Crowns, Caps, X-Rays, Extractions or Impacted teeth removed, Dentures, (Other) _____.

1. **CONSENT FOR GENERAL EXAMINATION OR CLEANING:** I understand that a routine dental cleaning involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. I understand that some bleeding after a cleaning may occur. I will notify the office if the bleeding persists and is severe in nature.

2. **REMOVAL OF TEETH**: Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the dentist to remove teeth. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain; swelling; spread of infection; dry socket; loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time; or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.

3. **CROWNS AND BRIDGES**: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown bridge, or cap (including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation in a timely manner. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying permanent cementation.

4. **FILLINGS**: I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common effect of a newly placed filling.

5. **DENTURES**: I understand that the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of 30 days, there will be additional charges.

6. **X-RAYS**: I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan. Our staff will not be able to diagnose and treat you without the necessary x-rays. We take standard protocol precautions to limit radiation exposure. If you have concerns about radiation exposure, please feel free to address them with your provider.

I understand that antibiotics, analgesics, and other medications may be used for one or more of the above procedures and can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. It is my responsibility to disclose to the practice prior to receiving services all medications being taken, allergies, or intolerances. 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. For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have read and discussed the preceding with the dentist or staff member, have been advised of the attendant dangers and possible complications, have been given a chance to ask questions, and have been given sufficient information to give my consent to the planned surgery. No warrantee or guarantee has been made as to the results or cure. I hereby authorize the dentist and their staff to proceed with treatment.

Signature of Patient/Guardian: _____ Date: _____

Printed Name: _____

Office Payment Policy

The following is an outline of our office payment policies. Please acquaint yourself with them and then sign below to acknowledge your understanding and acceptance of them.

FEES

Please feel free to discuss our fees with us at any time. Before any dental treatment begins, the patient and/or responsible party will receive a consultation regarding treatment plan and cost. We attempt to keep our fees at a fair level that reflects the quality of care provided in our office. Prompt payment will enable us to keep our fees lower for everyone; therefore, ***payment is due at the time services are rendered***. For procedures that take multiple appointments to complete, payment maybe split up over the number of appointments required. We accept cash, check (returned check fee $30), Visa, MasterCard, and Discover. We also offer CareCredit with no interest for 18 months or longer payment terms with competitive interest rates (WAC).

INSURANCE

As a courtesy to our patients with insurance we will file your insurance claim and allow you to pay only your deductible and/or estimated co-payment as services are rendered. Please remember that the contract is between you and your insurance company, and your total balance is always your responsibility. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on information provided to us. However, we have no way to guarantee the actual terms of your insurance company's payment, you will be sent a statement. Disputes regarding reimbursement or the amount are between you and your insurance carrier.

PAST DUE ACCOUNTS

Account aging begins the day your charges are incurred. Accounts that are ninety days past due will be referred for collections. This action will cause additional fees to be added to your unpaid balance including but not limited to collection fees, attorney fees, and interest as allowed by law. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once an account is turned over to collections, we will ask you to seek the services of another dentist and will no longer take responsibility for your family's dental care.

I have read, understand and agree to adhere to the financial policies above.

Signature_____ Date_____

I acknowledge that I have received a copy of Herron Regional Dental Centers Notice of Privacy Practices.

Signature_____ Date _____