Kerr Dental Associates

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent
Name: _____
Address: _____
Telephone: _____
Patient #: _____ Social Security: _____

Section B: To the Patient—Please Read 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 disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice is available at your request. 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:
Contact Person: Front Desk
Telephone: 508-747-5400 **Fax:** 508-747-8369
Address: 3 Market Crossing , Plymouth, MA 02360
Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. 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 healthcare operations.

Signature: _____
Date: _____

If this consent 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. Include completed Consent in the patient's chart.

INFORMED CONSENT FOR GENERAL 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 the 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 man 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_____

Restorations_____ Crowns_____ Bridges_____

Other____ 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 my permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials____

_____ _____
Patient Signature **Date**

If for Minor:
Parent/Responsible Party's Signature:
_____
Relationship to Patient: _____
Responsible Party SS#: _____

MORE IMPORTANT INFORMATION ABOUT OUR OFFICE

We are contracted providers with Blue Cross Blue Shield of Massachusetts (except for their HMO plans), Delta Dental and Harvard Pilgrim Health**.** We will submit claims to all insurances, whether we are participating or not.

Financial Policy: Prior to an appointment where a balance will be owed by the patient, we will provide a written estimate stating cost of treatment, estimated insurance and patient responsibility. Payment in full of patient portion is expected at time of appointment unless a payment plan is in place or we have a credit card on file.

We place only white fillings (composite resins) in our office. *Please note that under most insurance plans, patient out-of-pocket expense is usually higher for white fillings.* At the request of a parent, we will place silver/amalgam fillings on a child's primary/baby teeth.

We require a set of Full Mouth X-Rays or Panorex X-Ray on file for every patient over the age of eighteen as a component of our standard of care. These are generally needed only every 5 years.

Fluoride treatments are done twice per year on children through the age of 16, including patients with braces, *unless a parent requests otherwise***. This may exceed your insurer's age limits or frequency maximums.** Feel free to speak with your child's hygienist if you have any concerns or questions.

Please be sure to let us know if you or your spouse participate in any Flex-Spending program (pre-tax dollars) through an employer.

Also, please be aware that you can carry more than one dental insurance plan if both you and your spouse are employed. This could result in full coverage for some services. Please contact our office (or your Human Resources Department) for further information.

OFFICE HOURS:

Monday:	7:00 am - 5:00 pm
Tuesday:	7:00 am - 5:00 pm
Wednesday:	7:00 am - 5:00 pm
Thursday:	7:00 am - 5:00 pm
Friday:	7:00 am - 1:00 pm
Saturday:	1/month (Sept through May) 8:00am-12:30pm

Cancellation Policy: We require at least 24 hours notice if you must cancel an appointment, otherwise a $50 fee will be incurred (see below for Saturday appointments). *We allow a one-time grace period to accommodate unforeseen circumstances.*

Failure to Appear/No-Show Policy: There will be a $50.00 charge assessed (see below for Saturday appointments).

Tardiness Policy: Adult patients who arrive more than 15 minutes late for an appointment may be rescheduled at the discretion of the provider. Children who arrive more than 10 minutes late for a cleaning may be rescheduled at the hygienist's discretion.

Saturday Appointments: If you are lucky enough to have a Saturday appointment, please be aware that ***these are premium appointments***. ***Therefore, we require all Saturday appointments to be confirmed by 5pm the previous Thursday afternoon or be subject to cancellation.*** Regretfully, this is necessary due to the high cancellation/no-show rate and costliness of having staff here with no patients.

Kerr Dental Associates

Name: _____

"THIS IS THE MOST IMPORTANT PIECE OF PAPER IN YOUR WELCOME PACKAGE!"

Help us get to know you better, sooner! Please thoughtfully reply to the following:

- *What is your main dental concern (appearance, comfort, health)?* _____
- *Are you having any sensitivity? Hot, Cold, Pressure (circle all applicable)*
  If so, where? Upper right, Lower right, Upper left, Lower left (circle all applicable)
- *Are you satisfied with the appearance of your teeth?* _____
- *What would you like us to know about you and your past dental experience?* _____
- *How is your overall health? Do you snore?* _____
- *Do you believe your teeth are connected with any general health problems?* _____
- *Do you feel nervous about having dental treatment?* _____
- *If so, what is your biggest concern?* _____
- *What about our practice appealed to you?* _____
- *Do you or any of your family members play sports?* _____
- *Any hobbies, interests or activities that you would like to share with us? We like to have magazines and reading materials of interest to our patients* _____
- *Reason for leaving previous dentist(circle one): moved insurance other**

If 'other', please explain _____

Thank you for your time!