

**CONSENT FOR ENDODONTIC EVALUATION ONLY**

I understand my tooth will be evaluated for possible endodontic treatment.

\_\_\_\_\_  
Patient Signature (Parent if Minor)

**SHOULD ENDODONTIC TREATMENT BE APPROPRIATE, PLEASE  
READ AND SIGN BELOW.**

**CONSENT FOR ENDODONTIC / EMERGENCY TREATMENT**

I understand that the root canal therapy is a treatment performed to retain a tooth which might otherwise require extraction. I have been informed of possible alternative methods of treatment including no treatment at all.

During root canal therapy, certain procedural complications can occur including but not limited to, i.e., numbness, separated (broken) instruments, blocked canals, root perforations, alteration of sensation, and damage to restorations.

Although root canal therapy has a high degree of success, it is still a biological procedure, and as such, cannot be guaranteed. Some teeth that have had root canal therapy may require re-treatment, surgery, or even extraction.

I understand that only the root canal treatment is to be performed at this office and that my restorative dentist will do the follow up treatment (filling, crown, etc.).

I understand that the dentists performing the endodontic treatment are specialists in this field.

\_\_\_\_\_  
Patient Signature (parent if minor)

\_\_\_\_\_  
Witness

*Revised 7-8-04*

Patient's Name \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone #s (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_  
Birth Date \_\_\_\_\_ Male  or Female  Social Sec. No. \_\_\_\_\_  
Employer (or Parent, if Child) \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Occupation \_\_\_\_\_  
General Dentist \_\_\_\_\_ Referred By \_\_\_\_\_  
Spouse's name \_\_\_\_\_ Daytime Phone (Work) \_\_\_\_\_  
Any Dental Insurance? Yes  No  Under Whose Name? \_\_\_\_\_ Group Number \_\_\_\_\_  
Dental Insurance Company \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Insured Party's Social Security Number \_\_\_\_\_  
Insured Employer \_\_\_\_\_

I hereby certify that the above information is correct.

\_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_

**Insurance Patients Only**

I authorize release of any information relating to this claim.

\_\_\_\_\_ Signed (Patient, or Parent if Minor) \_\_\_\_\_ Date \_\_\_\_\_

I wish to assign benefits to the providing dentist. \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_ **OVER**

⇨ MEDICAL HISTORY ⇨

Name of Your Physician \_\_\_\_\_ Phone # \_\_\_\_\_  
Do you require antibiotics before dental treatment? Yes  No  If yes, give reason \_\_\_\_\_  
Have you been hospitalized in the last 5 years? Yes  No  If yes, for what? \_\_\_\_\_

Please list all medications you are taking \_\_\_\_\_

Do you have, or have you had, any of the following?

- Mitro valve prolapse
- Heart disease (angina, heart attack, bypass)
- Pacemaker or artificial valve
- Rheumatic fever
- High/low blood pressure
- Shortness of breath
- AIDS, HIV, or high risk
- Lung disease or Tuberculosis
- Blood disorder (describe below)
- Excessive bleeding from a cut or extraction
- Malignancies/ cancer
- Radiation or chemotherapy treatment
- Thyroid or parathyroid condition
- Hepatitis/ liver problems
- Diabetes
- Excessive thirst/ urination
- Stroke
- Hip or joint replacement
- Sinus Trouble
- Glaucoma
- Ulcer or Colitis
- Venereal disease
- (Women) Are you pregnant
- Kidney disorder

Allergies to medications (i.e.: Penicillin or “Novocaine”) \_\_\_\_\_  
Is there any other medical information the doctor should know? \_\_\_\_\_

## FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policy so that we can minimize our billing cost.

**All patients must complete our Office Health History and Financial Policy in its entirety prior to being seen by the doctor.**

Payment is expected at time of service, unless other arrangements have been made, prior to treatment.

### **INSURANCE:**

The patient (or responsible party ) is responsible to pay any deductible and percentage due **AT THE TIME OF SERVICE**. The percentage quoted you is **an estimate** and not a guarantee of payment from your insurance company. In order for us to file claims in your behalf, you must supply us with all necessary insurance information. Please refer to your insurance manual for specific coverage. Your insurance policy is a contract between you and your insurance company. If your account has not been paid within 45 days, **the balance will be due in full by you , regardless of insurance status.**

- For the plans which we are participating provider,** we will submit the claim for you.
- For the plans which we are not a participating provider,** if your insurance company accepts electronic claims, we will, as a courtesy, submit the claim to your insurance carrier. If an overpayment occurs, we will refund you that payment within 7-10 business days.
- If your insurance company does not accept electronic claims,** you will be responsible for all charges **AT THE TIME OF SERVICE**. We will provide you with a coded description of treatment rendered for **you** to file for reimbursement.

### **Minor Patients:**

Unaccompanied minors will **not** be seen without written permission from a parent or guardian. The parent, guardian or adult accompanying a minor is responsible for full payment, their deductible, or percentage, **AT THE TIME OF SERVICE**. For unaccompanied minors, non-emergency treatment will be denied unless charges have been prepaid or the minor comes prepared **AT THE TIME OF SERVICE**.

### **Finance Charges**

Any account balance carried over 45 days will be subject to a \$15.00 billing fee, or a 1.5% interest fee per month, whichever is greater. In the event the account is turned over to a collection agency, the patient or responsible party shall be liable for any clerical, legal, and collection fees incurred, up to 30% of the outstanding balance. **Note:** Balances sent to a collection agency will be billed at our usual and customary fee.

### **Acceptable Methods of Payment:**

We accept personal checks\*, cash, as well as VISA, MasterCard, American Express, & Discover.

\*Checks returned from the bank will be subject to a service fee of \$35.00. **A fee of \$75.00 per half hour may be charged for any appointment cancelled without 48 hours notice.**

**I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY**

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

*Revised 5-26-04*

# NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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## **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04-14-03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use generic medical alert stickers on the front of your chart to alert the providing doctor and staff to pertinent health information about you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make

reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page, \$25 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jan Phelps -

Telephone: 301-231-0744 -

Fax: 301-770-1322 -

Address: 11125 Rockville Pike, Suite 103, Rockville, MD 20854 -

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**This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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## For Office Use Only

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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
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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