New Patient Agreements/Consents

HIPAA Agreement:

HIPAA OMNIBUS RULE: PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims. The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____ Date: _____
Please print name of Patient Please sign for Patient / Guardian of Patient

_____ _____
Legal Representative /Guardian Relationship of Legal Representative /Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

□ First Name Only □ Proper Sir Name □ Other: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:
□ Cell Phone Confirmation □ Text Message □ Home Phone Confirmation □ Email Confirmation □ Work Phone Confirmation
□ **Any of the Above**

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:
□ Cell Phone Confirmation □ Text Message □ Home Phone Confirmation □ Email Confirmation □ Work Phone Confirmation
□ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFORMATION on behalf of this Healthcare Facility via:
□ Phone □ Text Message □ Email □ **Any of the Above** □ **None of the above (opt out)**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

DENTAL TREATMENT CONSENT:

1. WORK TO BE DONE
I understand that I am having the following work done:
□ Fillings □ Bridges □ Crowns □ Extractions □ Impacted Teeth Removed □ General Anesthesia □ Root Canal □ Cleaning □ Other: _____

2. DRUGS AND MEDICATIONS
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction)

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.

4. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc..) and I authorize the Dentist to remove the following teeth_____ and any others necessary for reasons in paragraph #3. 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 (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalized if complications arise during or following treatment, the cost of which is my responsibility.

5. CROWN, BRIDGES AND CAPS
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, size, and color) will be before cementation.

6. DENTURES, COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. the cost for this procedure is not included in the initial denture fee.

7. ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy)

8. PERIODONTAL LOSS (TISSUE & BONE)
I understand that I have a serious condition causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

STATEMENT OF FINANCIAL POLICY:

We thank you for choosing Waukesha Dental Solutions for your dental care. We hope that we fulfill all your dental needs and invite any questions or concerns.

Our office accepts multiple insurance plans, and we will do our best to assist you in maximizing your plan. However, it is **your responsibility** to verify your insurance coverage and anything not covered by your insurance will be **your responsibility**. Please bring your insurance card to all your appointments. It is utmost importance that we have current information on all our patients. All charges not covered by insurance, co-pays and deductibles are due at the time of service.

Insurance companies should pay their portion or deny claims withing 30 days of the claim day. If our office does not receive either payment or denial on behalf of your claim, we ask that you help us in resolving the issue and hold you responsible for the charges until it is resolved. **Any unpaid balances become your responsibility**.

Patients who do not have dental insurance are expected to pay in full at the time of service. If the fee for treatment is unaffordable, we ask that you make financial arrangements **PRIOR** to treatment.

When scheduling appointments please give special consideration to the time, as that time is reserved especially for you. When an appointment cannot be kept, our office requires 48-hour notice, and reserves the right to charge for a cancelled appointment, and if not notice given a failed appointment charge. Patients missing 2 consecutive appointments may be dismissed.

Our policies are designed to be fair and equitable to all patients who present themselves for care. If there are any unusual circumstances, we need to know. Feel free to discuss services, fees, or any special needs with us prior to treatment. Your care is most important to us, and we hope to retain good communication between our family and yours.

I have read and understand the above and agree to the policy terms.

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

APPOINTMENT AGREEMENT:

Welcome to our practice. We are honored that you have selected us for your dental needs and wants.

We are committed to providing quality service to all our patients.

We believe that an important aspect of delivering exceptional dental care is our patients' commitment to our practice as well.
Therefore, we request that you honor your reserved appointment as scheduled. Should you have to change your appointment for any reason, we ask that you give us 48 business hours' notice.

Because missed appointments increase the cost of healthcare for everyone, should you miss two appointments in which 48 hours' notice is **NOT** given, you may be required to pay a deposit before we reserve your next appointment. The deposit fee would then be applied to any treatment rendered, or forfeited if the reserved appointment is missed or cancelled without giving the required 48 hours' notice. We appreciate your understanding in this matter.

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

WEBSITE AND SOCIAL MEDIA RELEASE:

I, the undersigned, do herby grant permission to Waukesha Dental Solutions to post my and/or my child's story, photo or other item hereinafter referred to as "Materials," I submit to and for Waukesha Dental Solutions Web site, Instagram account and Facebook account. I hereby release you, your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors, from all claims and demands arising out or in connection with any use of said "Materials," including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights. I acknowledge and agree that no sums whatsoever will be due to me as a result of the use and/or exploitation of the "Materials" or any rights therein.

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Address: _____

I acknowledge that my child is under the age of 18 years old and lacks the legal capacity to enter into binding agreements. Accordingly, I have read this release and consent to my child inclusion in the "Materials" will not contest the rights granted in this release, and shall assist and support you in any and all legal proceeding for affirmation of this agreement, should you choose to have a court of law affirm this agreement.

Child's Name: _____ Date: _____

Parent of Legal Guardian Signature: _____