HUEBNER DENTAL GENERAL CONSENT

Consent to Treatment

I have presented myself to this facility for dental care and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. I realize I have the right to refuse any treatment or procedures to the extent permitted by law. During the course of treatment, I may undergo procedures in all phases of dentistry including dental prophylaxis, periodontics (gum treatment), oral surgery, fixed and removable prosthodontics (crowns, bridges, and dentures), restorative dentistry, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

HIPPA

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 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 use and/or disclose health information about you for treatment, payment and healthcare operations. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you. We may use and disclose your health information to obtain payment for services we provide to you.

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 disclose it to anyone for any purpose. If you give us an authorization, you make revoke in writing at any time. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Family/Friends: We must disclose your health information to you, as described in the patient's 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, only if you agree that we may do so.

Please list family/friend you wish to authorize at this time here:

Name: _____ Relation: _____

For patients 18 years and older under parent insurance policy, please authorize a parent to receive information regarding your dental record and billing.

Healthcare Providers: 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, or 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 not use your health information for marketing communications without your written consent. **We may use or disclose your health information when we are required to do so by law.

Patient Benefits Provided by Your Insurance Company

I acknowledge that my dental benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/ or coinsurance. I acknowledge that I should contact Huebner Dental if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment. I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I acknowledge that I am responsible for any balance not covered by my insurance and that I have the right and responsibility to follow-up with my insurance for specific questions regarding my individual policy.

I authorize the use of my signature on file for all insurance submissions Yes ____ No _____

Cancellation Policy

Huebner Dental require a 24 hours cancellation notice upon cancelling an appointment. If prior notice is not given, you will be charged in full for the missed appointment. The Fee applied will be $50.00

Communication

I consent to receive information; such as appointment reminders, patient surveys, and other information relating to my dental treatment via phone, text and email provided.
Your email address will be kept confidential and will be not shared.

Please reply to the text or email confirmation. Appointment confirmation is required to keep your appointment.

The cell phone number I authorize is: _____

The email address that I authorize is: _____

Photo/Video Authorization

I grant to Huebner Dental, and its employees the right to take photographs and\or videos of me. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

☐ Agree or ☐ Decline

Patient Name (Please print): _____

Patient or Guardian Signature: _____ Date: _____