CONSENT FOR TREATMENT

I authorize White Pine Dental to perform any necessary dental services with my informed consent and assume all risks associated with treatment in the hope of achieving better health.

I understand that there are certain risks associated with the use of anesthetic which can lead to bruising, muscle soreness, cardiac stimulation, temporary or even permanent numbness to the lips or toungue. Also, with basic dentistry such as fillings and cleanings the teeth remain sensitive or even possibly painful after treatment. After lengthy appointments jaw muscles may be sore or tender. Gums and soft tissue may also be sensitive or painful during and after treatment. Although rare, it is also possible for the tongue, cheeks or other oral tissue to be inadvertantly abraded or lacerated during routine dental procedures.

I understand that as part of dental treatment items including, but limited to crowns, small dental instruments, drill components, etc. may be aspirateded and swollowed. This unusual situation may require a series of x-rays to be taken by a phsysician or hospital and may in rare cases, require bronchosopy to ensure safe removal.

_____ _____

Signature of Patient or Guardian Date

HIPPA PATIENT CONSENT

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing. The practice provides this form to comply with the Health Insurance Portability and Accountability Act 1996 (HIPAA). A detailed description of the HIPAA policy is available for your review upon request.

May we leave a recorded message regarding your financial responsibilities on your home or cell phones? ☐ YES ☐ NO

This consent was signed by: _____ ☐ Patient ☐ Parent ☐ Guardian

Date signed: _____

OFFICE FINANCIAL POLICY

1. Our office provides insurance claim submissions as a courtesty to our patients. You are directly responsable to the doctor for your account irrespctive of your insurance schedule. You will be billed for any insrance clains that are outstanding in excess fo 60 days.
2. If you dont have insurance, or you carry an insurance that does not reimburse our office, charges for services are due and paybale at the time services are rendered.
3. We accept cash, personal checks and Visa, Mastercard, Discover, and American Express credit cards.
4. I agree to pay a $40.00 fee on all returned or cancelled checks.
5. I understand that there is a no show/cancellation fee for all appointments. The fee is determined by the amount of time reserved for the visit ($24-$500). No fee will be charged if appointment is cancelled with a 48 hour notice.

I understand the following: I agree that failure to make a payment or to contact this office for 2 consecutive months will result in my account being referred out to a collection attorney and all payment arrangements must then be made with them. In addition to my account balance, I agree to pay a collection fee of 40% of my outstanding balance and any additional collection agency fees, attorney fees and court costs.

I authorize and request my insurance company to pay insurance benefits directly to the dentist or dental group. I understand that my dental insurance carrier may pay less than the actual bill for service and that I will be responsible for payment of all services rendered on my behalf.

_____ _____

Signature of Patient or Guardian Date