

# General Consent Form

- **Health Information**

I agree to disclose all previous illness and medical history. Undisclosed medical information and current medications, allergies or illnesses may complicate my dental treatment. I understand that latex gloves, antibiotics, local anesthetics and other medications can cause mild to severe allergic reactions. Also, some antibiotics can interfere with birth control pills. Epinephrine in local anesthetics can cause temporary increase in heart rate and may be dangerous in rare cases.

- **Fillings, Crowns and Unanticipated Root Canals**

Some teeth may need a root canal even after a simple filling. Fillings and crowns are performed to treat diseased teeth and a small percentage of these teeth end up needing a root canal after the filling or crown.

- **Root Canals**

Root canals are performed in an attempt to save a diseased tooth. Root canals have a high success rate but they can fail and may require additional or specialized treatment. In some cases, the tooth may even need to be extracted.

- **Porcelain Crowns, Veneers, Bonding and Cosmetic (White) Fillings**

All of these dental procedures are esthetically pleasing; however, they may chip or break at some point in the future. The patient is responsible for repairs or remakes. Sometimes it is impossible to exactly match the color of your natural teeth. Once a crown or veneer has been done, the color *cannot* be changed. ***Bright Dental Center only places composite (white) fillings***, not amalgams (silver). If there is a difference in coverage by your insurance company relating to what particular material is used, ***you will be responsible for the difference.***

- **Periodontal (Gum) Treatments**

When regular cleanings are missed or daily hygiene is not properly done, periodontal disease can result. This is the destruction of bone that supports teeth. All new patients to our practice are required to undergo a complete dental exam with x-rays and a periodontal evaluation. I understand that if I have periodontal disease, I will need more than a regular cleaning.

- **Extraction and Surgery**

I understand that all dental extractions and surgeries carry risks. If surgery is needed, those risks will be explained to me.

- **Fees for Additional or Specialty Care**

I understand that I may require treatment beyond what was planned such as when a tooth is crowned and later needs a root canal. Also, I may be referred to a specialist for additional care. I agree to be financially responsible for the additional or specialty care.

- **24 Hour Notice for Cancellation and Tardiness**

*Initial* \_\_\_\_\_

***I agree to give 24 hours notice if I need to cancel an appointment or pay a broken appointment fee of \$35 per hour appointed.*** If I am more than 15 minutes late for my appointment, I will either take the time remaining for my appointment or reschedule and pay the broken appointment fee.

- **Changes in Dental Treatment**

Treatment can be complicated and while we try to anticipate any potential changes to a treatment plan in advance, we may not be able to realize some problems with teeth and the surrounding tissue until treatment has begun. If at this point additional treatment is needed, we will inform you.

- **Family Members in the Treatment Areas**

We have limited amount of space in the treatment areas of our office. Our facilities do not allow for non-patients to be present chair-side. One adult may accompany a minor to the treatment area if you desire. However, we ask that no more than one family member be present. We cannot be responsible for managing your unsupervised children while you are undergoing treatment. Our services require the full attention of the doctor and our staff.

- **Payment Policy**

**Initial** \_\_\_\_\_

**Payment is expected at the time of service.** High quality dentistry is made more affordable now with various payment options. We accept most major credit cards and we provide a courtesy discount of 5% for cash and check payments. Payments must be made with cash or check; this discount does not apply to payments made with a credit or debit card, or to insurance co-pays. **There is a \$35 fee for any check returned unpaid.** We also have interest free or extended payment options provided by a financing company such as Care Credit for your convenience. We ask that new emergency patients pay in full for their initial appointment. This helps to establish a payment history in our office.

**IN THE EVENT ON NON-PAYMENT OF CHARGES FOR DENTAL SERVICES RENDERED, I AGREE TO PAY ALL COSTS OF COLLECTIONS, INCLUDING REASONABLE ATTORNEY’S FEES AND COURT COSTS. I FURTHER AGREE TO PAY THE LEGAL RATE OF INTEREST ON THE ACCOUNT UNTIL PAID IN FULL AND HEREBY WAIVE ALL RIGHTS OF EXEMPTION UNDER THE CONSTITUTIONAL LAWS OF THE STATE OF ALABAMA. I UNDERSTAND THAT A 1.5% CHARGE WILL BE ADDED TO ALL ACCOUNTS 30 DAYS PAST DUE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- **Limitations of Insurance Coverage**

Insurance may not cover every procedure that we recommend. Some examples include nitrous oxide, temporary dentures, removal of crowns or bridges, bleaching or cosmetic work. I understand what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what insurance does not cover. We will also do our best to help you understand your benefits. Unfortunately, we are unable to keep track of the multitude of insurance plans or the changes that regularly occur. We gladly process and submit the insurance claim on your behalf; but please note that an insurance benefit is a contract between you (the patient) and the insurance company.

- **Filing Dental Insurance for the Patient**

We routinely file insurance claims for the patient *as a courtesy*. The patient is still fully responsible for the payment of all charges incurred within the office. We reserve the right to discontinue filing insurance claims for the patients at any time. If this occurs, the patient will then be responsible for the payment of all fees in full at the time service is rendered.

**I HAVE READ THE PRIVACY NOTICE AND UNDERSTAND MY RIGHTS CONTAINED IN THE NOTICE. BY WAY OF MY SIGNATURE, I PROVIDE BRIGHT DENTAL CENTER, LLC WITH MY AUTHORIZATION AND CONSENT TO USE AND DISCLOSE MY PROTECTED HEALTH CARE INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS AS DESCRIBED IN THE PRIVACY NOTICE.**

Patient’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I consent to appointment confirmation by: Text \_\_\_\_\_ Email \_\_\_\_\_**