Blaine and Birch Bay Family Dentistry
310 Martin St.
Blaine, WA 98230

INFORMED CONSENT
GENERAL DENTISTRY

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand that the doctor will give me a treatment plan after my oral examination (if I need any dental work) and the dental work that I will have done will be completed as detailed in the treatment plan (if applicable).

(Initials_______)

2. DRUGS AND MEDICATION

I have been informed and 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). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). (Initials_______)

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 discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. These changes will be discussed with me and I will have the opportunity to verbally agree or decline the change in treatment, unless it is not practical due to a dental/medical emergency. (Initials_______)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the

need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. (Initials_______)

5. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care and that I will be responsible for the charges not covered by my insurance company. I understand that the dental office will submit dental claims to my insurance company as a courtesy but that submitting insurance and receiving a benefit is my responsibility. (Initials_______)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Patient's Signature______________________________

Date _____________________________________

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CONSENT FOR SERVICES

Financial arrangements:

At Blaine and Birch Bay Family Dentistry, it is our goal that our patients understand their treatment needs as well as their financial responsibility. In order to provide quality care to our valued patients, we only accept payments in full the day of scheduling treatment and offer the following financial arrangements:

- **Patient without insurance:** Payment for all dental services is due at the time of scheduling for all dental work.
- **Patient financing:** Payment plans through Care Credit are available based upon credit approval.
- **Patient with insurance:** Estimated portions not covered by your insurance are due at the time of scheduling for all dental work.

I am responsible for my balance if any of the following occurs:

- The treatment goes over my yearly maximum designated by my Insurance Company
- Any treatment that is denied by my Insurance Company.
- If I am not eligible for insurance
- I prevent or delay payment by not complying with requests for Insurance forms or signatures.
- I do not complete my treatment and it results in non-payment by the Insurance Company.
- I receive my insurance check and do not send it to the office.
- I give false Insurance information resulting in Non-payment or inaccurate estimates.
- I cancel my dental appointment with less than 24 hours' notice.

I hereby authorize payment directly to the above named dental group. I understand that I am financially responsible for any charges not covered by this authorization. I hereby accept the foregoing treatment plan and authorize release of any information relating to this claim.

Our office will gladly fill out and submit all insurance forms on your behalf. However, you understand that you are personally responsible for your account. Before any treatment, our office will estimate your patient co-payment portion for each procedure. Please keep in mind that these amounts are only **ESTIMATES** based on information provided by your insurance company. Any balance remaining after payment from the insurance company is the patient's responsibility.

Finance Charges:

A finance charge of 18% per year will be applied to all accounts after 90 days. A NSF fee of $25 will apply on all returned checks.

Less than 48 hours Cancelation or No-Show Charges:

If you cancel your appointment with less than 48-hour notice or do not show to your appointment, you will be charged $100 per hour for the time lost. (Fee waiver will be considered on a case-by-case basis)

I have read and understand the terms of the above agreement.

______________________________ ____________________

Patient (or guardian) signature Date

GETTING TO KNOW YOU

Your Family Members

Are there other members of your household who are not patients at our office? ☐ Yes ☐ No
Please list names:

1.______________________ 2._____________________

3.______________________ 4._____________________

How did you hear from us?

☐ Google/internet ☐ Drove by/walked by

☐ Delta Dental Provider List ☐ Regence Provider List ☐ Humana Provider List

☐ Other____

☐ Referred by____

COMMUNICATION CONSENT FORM

<u>CONSENT TO VOICE MESSAGES</u>: I authorize Blaine & Birch Bay Family Dentistry to leave protected health information (PHI) on voice mail or other telephone messaging services. These messages may contain information about your appointments or personal health information. If you authorize this, you should be aware that voice mail and other telephone messaging services are not secure or private, and as such, unauthorized people may be able to retrieve and hear such communications.

Please initial in the space for each of the following permissions if you agree:

I give Blaine & Birch Bay Family Dentistry permission to leave a message on my:

__________ Mobile voice mail Phone: ______________________

__________ Home voice mail Phone: _______________________

__________ Work voice mail Phone: ________________________

If I cannot be reached directly or by voice mail, the Practice may leave a message with my:

Spouse Name/Other: ________________________ Phone: _______________

<u>CONSENT TO TEXT MESSAGES</u>: Blaine & Birch Bay Family Dentistry may use text messaging for reminders and to communicate health information. I agree that Blaine & Birch Bay Family Dentistry may communicate with me via text messages. I am aware that there is some level of risk that third parties might be able to read unencrypted messages. By opting in, I hereby authorize Blaine & Birch Bay Family Dentistry to send text message appointment reminders or communicate with me on my provided cell phone number. I understand that when prompted, I may confirm future appointments using this text messaging service. By accepting these terms, I agree that all individuals associated with my account my receive

alerts referencing the account dependents. Text message charges from my cell phone provider may apply (if no text messaging plan).

I consent to text messages. _____My Mobile Number is: _________________________

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted in writing to the Privacy Officer/ Officer Manager at: Blaine & Birch Bay Family Dentistry, 310 Martin St, Blaine WA 98230

Patient's Name: _______ _______________ _____Signature and date: _________________

Legal Guardian's Name: ____________________ Signature and date: __________________

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Notice of Privacy Practices Acknowledgement

We keep a record of the heath service we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting N. Chen.

Our **Notice of Privacy Practice** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

______________________________ ______________________________
Patient or legally authorized individual signature Date Time

______________________________ ______________________________
Printed Name if signed on behalf of the patient Relationship

This form will be retained in your dental record

Last Updated: 07 / 22 / 2014

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310 Martin St
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NOTICE OF PRIVACY PRACTICES

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.

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 April 1, 2006, 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 the Notice, please contact us using the information listed at the end of this Notice.

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 dentist, physician or other healthcare provider providing treatment to 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 but is not limited to quality assessment and improvement activities, 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 of your healthcare, unless you object.

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.

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

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 may 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. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Restrictions: 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).

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.

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.

If you have any questions or special requests please inform the front desk or any of our staff and they can make the HIPAA officer available to you.

Contact Officer: N. Chen
Telephone: 360-332-9534
Address: 310 Martin St, Blaine WA 98230