Magnolia Springs
DENTISTRY

General Consent Form

Patient Name:_____ Date of Birth: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

I do hereby authorize and request the performance of dental services that Magnolia Springs Dentistry may deem necessary for my treatment. I understand that Magnolia Springs Dentistry will use clinical and patient management techniques that are reasonable, necessary, and advisable. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I may request or authorize.

I authorize the administration of antibiotics, anesthetics or analgesics that may be deemed appropriate by Magnolia Springs Dentistry. I understand that the purpose for using local anesthetics may be therapeutic, diagnostic, or for the treatment of facial pain. I understand that these medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **It is the patient's responsibility to notify us of any known allergies prior to treatment.**

I acknowledge that there are risks of local anesthetics including, in very rare instances, allergic reactions and swelling and/or bruising of the injection site. There is also a small risk of altered sensation or numbness to the chin and lip from some types of lower injections. This paresthesia is most always temporary but in rare cases can be permanent.

In order to effectively diagnose conditions of the oral cavity including decay, periodontal disease, tumors, cysts or conditions of the bone, it is necessary to have or take radiographs. As a new patient, I understand that **I am responsible for obtaining any current x-rays that may have been taken at a previous office prior to my initial appointment.** If proper diagnostic films are not available, they will be taken as needed or your appointment will be rescheduled.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, it may become evident that additional procedures or treatment is needed. Magnolia Springs Dentistry will always advise you of any changes. I understand my relevant personal health information may be released to my insurance company in order to get reimbursement. In the event that Magnolia Springs Dentistry is exposed to my blood or bodily fluids, I agree to have my blood drawn and tested for Hepatitis B, Hepatitis C, and the Human Immunodeficiency Virus. I understand that testing would be done in a confidential manner, and would be made available only to the person who was exposed, and that person would be advised of my rights regarding protected health information.

Patient Signature:_____ Date: _____

Signature of Parent, Guardian, or Personal Representative: _____

Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN.

Financial and Dental Insurance Agreement

Magnolia Springs Dentistry

We are committed to providing you with the best possible care. In order to do this, we need your assistance and understanding of our payment policy.

- ***Payment for services is due at the time of services rendered,*** unless our staff has approved other payment arrangements in advance. We accept cash, checks, Visa or MasterCard.
- As a courtesy, we will contact you a day or two before to confirm appointments.
- It is the patient's responsibility to have all records at our office prior to their appointment unless worked out with the front office in advance.

Understanding Dental Insurance

Navigating through the constantly changing world of dental insurance can be quite complicated. We would like to help you understand the world of dental insurance. Often, we find ourselves in a challenging position of trying to predict what insurance coverage will be. Despite our best efforts, the insurance companies frequently do not provide us with adequate or correct information about your benefits, which affects our ability to estimate the patient financial responsibility. Even a preauthorization does not guarantee payment from your insurance carrier.

Please know that we feel your frustration, and truly want to help. We cannot dictate or control what the insurance companies decide. Our main goal is to provide the highest level of ethical, quality dentistry for your family and develop relationships based on trust.

We will gladly assist you with your insurance claims with the following understanding:

- As a courtesy to our patients, we will file your insurance claim and allow you to pay only your deductible and/or estimated portion as services are rendered. While we are happy to work with your insurance carrier to maximize your benefits, please know that insurance only provides us with estimates of coverage, never guarantees. Please remember that the contract is between you and your insurance company, and your total balance in our office is always your responsibility.
- We make every effort to give you an accurate estimate of what your portion of our fees will be, based on information provided to us. However, we have no way to guarantee the actual term of your insurance policy. If for any reason there is a balance remaining after your insurance payment, you will be sent a statement. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier.

Accounts that are 90 days past due will be turned over to a third party collection agency. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once your account is turned over to collections, we will ask you to seek the services of another dentist and will no longer take responsibility for your family's dental care.

I authorize release of any information relating to treatment and direct payment to Magnolia Springs Dentistry. I understand and agree that (regardless of my insurance status) I am ultimately responsible for all costs of dental treatment.

_____	_____	_____
Patient Name	Date	Signature of Patient

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.

This Notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purposes permitted or required by law. It also describes your rights concerning your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to follow the practices described in this Notice. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information we maintain at that time including health information we created or received before we made the changes.

You may obtain a copy of our Notice of Privacy Practices at any time by calling our office or requesting one at your next appointment.

Uses and Disclosures of Health Information

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We may use and disclose your information to obtain payment for services we provided to you. For example we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment. We may call to remind you of an appointment and if you are not available we may leave a message on your voice mail or with another member of your household.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Others Involved in Your Health Care: 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 or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgement or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

Emergencies: In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule, Section 164.500 et. seq.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Additionally, we may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Military Activity and National Security: When the appropriate conditions apply, we may disclose, to military authorities, protected health information of individuals who are Armed Forces personnel. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: we may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Your Rights

Your rights with respect to your protected health information and how you may exercise those rights are outlined below.

You have a right to obtain a copy and/or inspect your health information: Health information includes treatment records, billing records and any other records used by us to make decision about your treatment. You may obtain a form from our office to request access. A reasonable cost-based fee will be charged for expenses such as staff time, copies and postage. Contact us as indicated at the end of this Notice to obtain information about our fees or if you have any questions about your access.

You have a right to request a restriction on the use and disclosure of your protected health information: You may ask us not to use or disclose some part of your protected health information for the purposes of treatment, payment or operations. You may also request that we not disclose some part of your information to family and others who may be involved in your care or for notification purposes as otherwise described in this Notice. We are not required to agree to the restrictions but if we do, we are obligated to abide by the agreement except in cases of emergency. You may request a restriction by sending your request in writing to our Privacy Contact.

You have a right to request to receive confidential communications by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to request an amendment to your protected health information. You may request that we amend protected health information about you. Your request must be in writing with an explanation as to why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures made by our Business Associates or us. It excludes disclosures for treatment, payment or healthcare operations as described in this Notice of Privacy Practices, to you, to family members or friends involved in your care, for notification purposes or as a result of an authorization signed by you. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 for up to the previous 6 years. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request an accounting more than once in a 12 month period, we will charge you a reasonable cost-based fee for responding to the additional request.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Questions and Complaints
If you have any questions, concerns or want more information about our privacy practices please contact our office.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we have made regarding your access to your health information or any other request you have made in the exercise of your rights, you may send your complaint to us using the information below. You may also submit a written complaint to the Secretary of Health and Human Services. Contact us for the address of the Department of Health and Human Services.

We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You may refuse to Sign This Acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

Authorization for Release of Information – Compound Release
Magnolia Springs Dentistry

Name of Patient:_____ Date of Birth: _____

I hereby authorize Magnolia Springs Dentistry and its affiliates, its employees and agents to release my personal health information in the following manner and to persons listed.

Magnolia Springs Dentistry is authorized to release my protected health information in the following manner:

We may communicate with you via: □ Voice mail □ Text Message □ Email

- Preferred E-mail address for Email communication: _____
- Preferred Cell Phone Number for Text Messaging: _____

** In order for email/text communication to occur, please accept & initial the disclosure below:

Initial_____Text/email communication: I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. It is my responsibility to update my email address. I still elect to move forward to allow email/text communication to occur.

Check each that can be given to the person/entity below

___ Treatment/Out of Pocket
___ Appointment Reminder
___ Breach Notification

Please list the full names of any individuals (family, friends, caretakers, etc.) that you would like to have access to your records and their phone numbers. The persons listed below will also be able to call our office and discuss your treatment.

_____

_____

Patient Rights:

- I have the right to revoke this authorization at any time by providing written notice to Magnolia Springs Dentistry.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ **Date** _____

Signature of Patient, Legal Guardian or Personal Representative