Informed General Consent

EMERGENCY DENTAL CARE: Emergency dental treatment is intended to provide relief of severe pain and infection for individuals in acute need. You, as a patient of record, have access to a 24-hour dental emergency service. There may be a charge associated with this service.

CONSENT TO DENTAL PROCEDURES: As a patient you will have access to current and complete information about your condition and will, unless otherwise specified, receive continuity of treatment, which may include treatment provided by dentists, be provided and estimate of the cost, and receive dental care according to a properly sequenced plan of treatment. Before receiving treatment you should ask the dentist about the procedures that he/she recommends you undergo, and ask any questions you may have before you decide whether or not to give your consent for the procedure. All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result of care. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance.

X-RAYS: Dental radiographic images will be made as necessary and appropriate for examinations, diagnosis, consultation, and treatment.

FINANCIAL RESPONSIBILITY: You will be charged for treatment according to the fee schedule in effect. A fee estimate will be provided prior to beginning treatment, and you must be prepared to pay for services as they are performed. Fees are collected in full at the completion of the procedure unless other arrangements have been made with the providing doctor. If for some reason payment is not made on the day of treatment, any remaining balance is due within 90 days. Failure to pay the balance within 90 days will result in the account being turned over to a collection agency. You will be responsible for any collection or legal fees which may be incurred as a result of your failure to pay for the dental treatment you received.

DENTAL INSURANCE: Freedom Dental will assist you with dental insurance by completing the claim forms and submitting them to the appropriate insurance provider.

DENTAL RECORDS: The Dental record, radiographic images, photographs, videos, models, and other diagnostic aids relating to your treatment are the property of our office. You have the right to inspect such materials and to request a copy of your dental records and radiographic images. A fee of $25.00 may be required for copying these items. You may also request to have your dental radiographic images sent to another health care provider by signing a 'Release of Information' form. The office also complies with requirements of the Health Insurance Portability and Accountability Act (HIPAA) and you will receive separate information, forms, and consent in that regard. In addition, your dental record may be used for instructional purposes and if it is, your identity will not be disclosed to individuals not involved in your care and treatment.

DISCONTINUANCE OF TREATMENT: Freedom Dental reserves the right to discontinue dental treatment whenever it is considered advisable and in the best interest of you and the dental office. Should treatment be terminated, any remaining credit balance for services not yet provided will be refunded to you.

I do hereby acknowledge, agree, and give my voluntary consent for treatment provided through Freedom Dental as may be deemed necessary or desirable by my treating professional(s), their assistants, and/or designees. This authorization includes, but is not limited to, routine diagnostic procedures, outpatient care, laboratory tests, and x-rays. I understand that my treatment may include a variety of interventions. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me as to results of examination and treatment received in the office. I acknowledge that my care is under the direction of my treating professional(s), and I represent that I will follow the instructions of my provider in the provision of said care.

Your signature on this form certifies that you have read and understand the information provided on the form, that you have received a copy, and that you accept dental care and treatment under the described terms and conditions.

Patient Signature (Parent/Guardian of Minor): Date:

X _____ _____