



### **Assignment and Release**

I, the undersigned, have insurance with \_\_\_\_\_ and assign directly to Palm Valley Family Dentistry, P.A. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance within 30 days from the date of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

### **Financial Agreement**

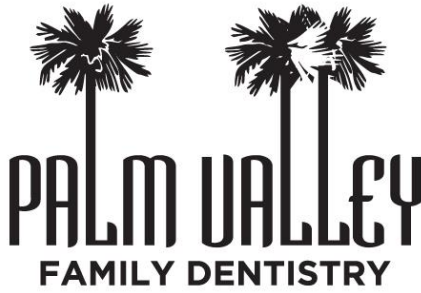
I acknowledge that payment is due at the time of treatment unless other arrangements are made. I acknowledge that all financially responsible parties are to be present for all treatment planning and financial estimates. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. In the event my account balance remains unpaid in excess of 90 days, I understand that my account will be turned over to a collections agency. I accept full responsibility for all administrative and legal fees associated with the collections process.

I understand that Palm Valley Family Dentistry has a broken appointment policy and I will be charged \$40 unless I notify the office at least 24 hours in advance for a cancelled appointment.

I understand that personal checks are accepted as forms of payment. I also understand that if a check is returned due to insufficient funds, I will be assessed a \$50 fee on my account.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, the undersigned, acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for the office of Palm Valley Family Dentistry as of today's date.

A copy of the signed, dated acknowledgement shall be as effective as the original.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

**Minor:** If you are the legal representative of the patient, please print the patient's name(s) and describe your authority:

\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize Palm Valley Family dentistry to discuss my dental diagnosis, dental treatment, appointments, and account information with the below named person(s).

\_\_\_\_\_  
\_\_\_\_\_

If you have any questions about this form, please contact the privacy officer, Dr. David Yoder.

Office use only:

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this acknowledgement but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- The patient was unable to sign
- Other

Signature: \_\_\_\_\_ Privacy officer



**Informed Consent for General Dental Procedures**

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. By consenting, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you follow your dentist's advice and recommendations regarding medication, pre- and post- treatment instruction, referrals to other dentists or specialists and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. The patient is an important part of the treatment team. In addition, complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition, advise your dentist immediately so that precautions can be taken or your physician consulted, if necessary.

If you are a woman on birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if you dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly know risks and complications of treatment include but are not limited to:

1. Pain, swelling, and discomfort after treatment.
2. Infection and the need for medication, a follow-up procedure, or other treatment.
3. Temporary, or on rare occasions, permanent numbness, pain, tingling, or altered sensation to the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations, or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restoration, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw and jaw related structures requiring follow-up care and treatment or consultation by a dental specialist.
9. Root tip, bone fragment or a piece of a dental instrument may be left in your body and may have to be removed at a later time.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for future treatment.
12. Allergic reaction to anesthetic or medication.
13. Need for follow-up treatment including surgery.

We believe in a complete diagnosis of all conditions in your mouth. **All new patients in our office will need radiographs of all areas of the mouth before any services can be provided.** If you have recently had x-rays taken at another dental office, please have them emailed or mailed to us. If these x-rays are not current (within 1 year) or are not of diagnostic quality or are not a complete set of x-rays, we will have to take new x-rays before any services can be provided. These new x-rays may not be covered by insurance and will be the patient's financial responsibility. **(Please initial.)**

This form is intended to provide you with an overview of potential risks and complications. Please discuss the potential benefits, risks and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Minor's name



## Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We are pleased to use the OralID screening device in our office. The OralID examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless, and completely safe.

Similar to other cancers, early detection of oral cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

### Who is at risk?

- Age 17+
- Tobacco use
- Alcohol use
- HPV infection

If you have any questions about risk factors, please feel free to talk to Dr. Yoder. We recommend all of our patients over 17 be screened with the OralID in addition to our routine visual cancer examination.

We feel very strongly that this is an important part of every new patient exam. To make the screening more accessible to our patients, **our fee is only \$30**. If you have insurance, we will gladly file this to your insurance company for you. Coverage on dental insurance plans is increasing, but unfortunately is still not guaranteed. If your insurance does not pay or if you do not have insurance, your fee will be \$30.

\_\_\_\_ Yes, I request your staff to perform an examination with OralID.

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

\_\_\_\_ No, I prefer not to have this examination at this visit.

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