**Elizabethtown Family Dentistry, PLLC**  **100 Robinbrooke Blvd. Elizabethtown, KY 42701 270-735-**1441

**GENERAL CONSENT FORM/HIPPA/INSURANCE ACKNOWLEDGEMENT/APPOINTMENT POLICIES**

 I am asking for dental/medical care for myself or my minor child at Elizabethtown Family Dentistry, PLLC. I agree to accept services which may diagnose and treat dental/medical conditions and routine dental care. I understand that these services may be provided by a dentist or a dental assistant or hygienist. I have not been given any guarantees as to the results of the services I will receive. My agreement to accept these services will remain in effect until I say otherwise. My agreement to accept these services is called a general consent and will include routine dental care including routine use of dental x-rays, local anesthesia, medication administration, and use of routine dental materials as well as emergency dental care and other non-invasive procedures. I understand that there are risks to routine dental visits including allergic reaction, pain, numbness, or other complications not stated here. I understand that I am financially responsible for any charges incurred on mine or my child's behalf. I understand that if my account is not paid when due, I am responsible for any fees incurred in an attempt to collect on the account, such as collection fees (based on a percentage at a maximum rate of 33 1/3% of the amount due at the time your account was placed with a collection agency), attorney's fees, and reasonable interest.

 I understand that if I am not compliant with treatment or continually miss or fail to show for appointments, I may be dismissed from the practice. I understand if I dismiss myself voluntarily from the care of Elizabethtown Family Dentistry, pllc, I will no longer be able to receive dental care, effective immediately upon my notification. I also understand Elizabethtown Family Dentistry may dismiss me (release me from their care), at any time and for any reason, and if this happens, I will be notified by phone/letter or both, and I will be able to receive emergency only dental care for a period of 30 days to allow me time to find a new dental provider. I give Elizabethtown Family Dentistry the right to discuss my dental/medical history and conditions with other healthcare providers as they deem necessary for treatment purposes.

 **PHOTO POLICY**

 I agree to allow Elizabethtown Family Dentistry,pllc to take myself/my family pictures and post to their website or facebook page and use for marketing or educational purposes SO LONG AS I GIVE WRITTEN CONSENT before pictures are posted/used.

 **HYGIENIST GENERALIZED SUPERVISION POLICY**

 Elizabethtown Family Dentistry, pllc may employ dental hygienists who have generalized supervision privileges. This additional hygiene license/certificate allows hygienists to perform regular uncomplicated dental cleanings on qualifying patients (those who are compliant with regular visits including dental exams and those who are not severely medically compromised), without the dentist physically on site in the building, but rather available by phone. These generalized supervision cleaning appointments will be done no more often than every other dental cleaning per patient.

 **APPOINTMENT POLICY**

 Please arrive on time to all appointments. If you must reschedule, we request a **24 hour** courtesy notice. This is an important courtesy to other patients and our staff. Failure to comply with recommended treatment schedules may prevent us from achieving your healthcare goals. Missing appointments without notifying us 24 hours in advance could result in a non-negotiable **$50.00 fee and/or dismissal** from our practice.

 **FLUORIDE POLICY**

 I understand that Elizabethtown Family Dentistry, pllc, as part of their recall program, will apply a topical fluoride treatment to all patients, 2 times per year at cleaning appointments and I understand the fee is $25 if not covered by my insurance. I also understand I may refuse this fluoride treatment by signing a fluoride release form.

 **MINOR POLICY**

 I understand all minors (<18), must have all consents and medical history signed by their parent/guardian and must also be accompanied by their parent/guardian to ALL appointments except regular cleaning appointments to include exam, cleaning, and possible x-rays. I certify that I am the parent/legal guardian of any minor consents I have signed/will sign. I understand dropping minor children off or leaving the building during appointments is not permitted.

**POLICIES ACKNOWLEDGEMENT**

I have read, understand, and agree to Etown Family Dentistry's photo, hygiene, appointments, fluoride and minor policies.

 Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_Self \_\_\_Guardian

**INSURANCE ACKNOWLEDGEMENT**

I authorize Elizabethtown Family Dentistry to release my healthcare information as needed for insurance payment purposes, and I assign insurance benefits to Elizabethtown Family Dentistry. I understand that E-town Family Dentistry files my insurance on my behalf as a courtesy and based on the information I give, and I take full financial responsibility for any non-covered charges.

 Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_Self \_\_\_Guardian

**PATIENT CONSENT**

I have read and understand all of the above Elizabethtown Family Dentistry, pllc consents and policies, and by signing below, I give my consent to treatment by Elizabethtown Family Dentistry, pllc.

 Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_Self \_\_\_Guardian

 Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPPA PRIVACY POLICY NOTICE**

**I acknowledge that I have received and read a copy of the Elizabethtown Family Dentistry's HIPPA NOTICE OF PRIVACY PRACTICES or refused to read.**

 Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_Self \_\_\_Guardian

 Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below I give my permission for you to release medical information and records concerning my medical or dental history, diagnosis and treatment to the following named person(s) below.. This can be in the form of phone or in person consultation with the named person(s). *This permission shall stay in effect unless I remove my permission by signature*.

**Permission granted to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_

 Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_