CENTER FOR DENTAL EXCELLENCE
•STEPHEN DELOACH, DDS, DPC•

Consent For Treatment

I, the undersigned, being the patient or the guardian of the minor patient, consent to undergo treatment discussed with the doctor.

I assume full responsibility for the payment of all such services regardless of insurance coverage and agree to pay for services rendered at or before completion of treatment, unless other arrangements are agreed upon in advance, with the doctor's office. If insurance has not paid their portion in 60 days from the date of treatment, it becomes my responsibility.

I understand that all payment for services is due within 90 days of the date of service, whether or not benefit reimbursement has been received. Should my account not be paid within 90 days, 1.5% interest per month, 18% per year, will be charged.

To insure that your treatment can be started without delay and be as effective as possible, we require that you notify us in advance (as stated below) for any changes in your appointment.

A **NON-REFUNDABLE DEPOSIT** is required to schedule an appointment longer than 1 hour.

A **2 BUSINESS DAY NOTICE**, prior to appointment time, is required for cancellation or the deposit will not be refunded.

A **1 BUSINESS DAY NOTICE**, for appointments without a deposit is required for any 1 hour appointment cancellation or there will be a $25.00 charge.

A **2 BUSINESS DAY NOTICE**, for appointments without a deposit is required for any 2 hour appointment cancellations or there will be a $50.00 charge.

I understand that all collection and/or attorney fees will be my responsibility.

Signature_____ Date_____

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Please help us get to know you!

1.) When I think about coming to the dentist, I feel:
- ☐ Comfortable
- ☐ Anxious
- ☐ Fearful
- ☐ Extremely Fearful

2.) I have avoided the dentist because of:
- ☐ My anxiety and fear
- ☐ Past experiences
- ☐ Cost
- ☐ Other_____

3.) Is keeping your natural teeth important to you? ☐ Yes ☐ No

4.) How long would you like to keep your natural teeth? _____

5.) The following things are important to me:
- ☐ Getting as much work done in as few appointments as possible
- ☐ Temperature of the treatment room
- ☐ Available financing
- ☐ Being able to use my insurance
- ☐ Being able to watch TV or listen to music while having dental work done
- ☐ Other_____

My preference would be:
- ☐ To be told in detail about what is going on in my mouth
- ☐ To be told in general about what is going on in my mouth
- ☐ To be shown pictures and movies so that I can understand what is going on in my mouth
- ☐ To talk with a team member about my dental problems and solutions

I have a fear of/concern about:
- ☐ Experiencing pain
- ☐ Not being numb
- ☐ Needles
- ☐ Unnecessary or wrong treatment
- ☐ Being scolded or made to feel ashamed
- ☐ Losing my teeth
- ☐ Having to wear a denture or partial
- ☐ Other_____

HIPAA PRIVACY ACT

HIPAA is a federal law developed to provide a standard of protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Center for Dental Excellence may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Center for Dental Excellence has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by HIPAA to distribute this notice to you and obtain acknowledgement that you have received the Notice. By signing below, you have indicated that you have received the Notice of Privacy Practice. I hereby acknowledge that I have received a copy of Center for Dental Excellence Notice of Privacy Practices.

_____
Initials of patient/guardian

Permission to Share Medical Information

My medical information may be obtained and exchanged verbally for the purpose of insurance, billing, and appointments with _____
Name/relationship

_____
Initials of patient/guardian

Permission to Bill Your Insurance

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me. Necessary forms will be completed by Center for Dental Excellence to help expedite insurance payments, however the patient is responsible for all fees regardless of insurance coverage including all collection costs, attorney fees, and court costs.

_____
Initials of patient/guardian

Communication

For appointment confirmations, billing, and dental questions we may contact you via home/cell phone and leave messages on an answering machine, voicemail, or email.

_____
Initials of patient/guardian