Dr. Christopher A. Molinar
2945 Harding Street, Suite 101
Carlsbad, CA 92008
(760) 730-0202

Dear Patients:

Our practice is committed to quality dentistry and to supporting you and your family in preserving life-long dental health. Our team is a group of skilled, caring professionals who take pride in outstanding personal service. If at any time you have questions regarding proposed treatment options, fees, or insurance, please ask our staff.

Payment is due at the time services are rendered, unless payment arrangements have been approved in advance. We accept cash, checks, MasterCard and Visa. We will be happy to process your insurance claims for you; however, your estimated co-payment is due at the time of treatment.

Account balances over 90 days will be subject to an interest charge of 18% per year. Delinquent accounts will be subject to all collection costs.

We must emphasize that as dental care providers, our relationship is with you, not your insurance carrier. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are the patient's responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Appointment times are reserved exclusively for you. Kindly give 48 hours notice if you are unable to keep your reserved time. **A fee of $55.00 per each scheduled hour** will apply for appointments that are broken or not given 48 hours notice.

Patient Name_____Date_____

I understand that it is my responsibility to understand the coverage of my dental plan or plans, to be sure that I am eligible to obtain covered services in this office, and that I am responsible for payment of any non-covered services.

I understand and agree that, (regardless of insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

Signature_____

Dr. Christopher A. Molinar

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Theresa Berry

Telephone: (760) 730-0202 Fax: (760) 730-0286

E-mail: _____

Address: 2945 Harding Street, Suite 101 Carlsbad, CA 92008

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

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

Include completed Consent in the patient's chart.

Christopher A. Molinar D.D.S.
Gentle State-Of-The-Art Care
2945 Harding Street, Suite 101
Carlsbad, CA 92008
(760) 730-0202

Name:_____ Date:_____

1. WORK TO BE DONE (Please initial each procedure):

I understand that I am to have the following work done:

_____ local anesthesia _____ bridges _____ fillings
_____ crowns _____ extractions _____ impacted teeth removed/oral surgery

_____ other:_____

2. DRUGS AND MEDICATIONS - I understand that medications can rarely cause allergic reactions, whose symptoms can include, but are not limited to: redness and swelling of tissues, pain, itching, vomiting, and /or anaphylactic shock (severe allergic reaction). I also understand that local anesthesia involves risks & hazards such as post-operative soreness, trismus (prolonged muscular spasm), allergic reactions, respiratory problems, paralysis, brain damage or even death.

Initials _____

3. CHANGES IN TREATMENT - I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the initial examination. Changes or additions in treatment will be approved by me before further treatment is rendered.

Initials _____

4. ORAL SURGERY/REMOVAL OF TEETH - Alternatives to removal/surgery have been explained to me (root canal therapy, crowns, bridges and periodontal surgery, etc.), as well as the hazards and consequences of non-treatment. I authorize the dentist to perform the following _____. I understand that tooth removal/surgery does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are bruising, pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) alteration of taste or fractured jaw. I authorize the dentist to make the decision during surgery to leave a small piece of tooth root in the jaw when it's removal would require extensive surgery and when possible damage could occur with removal. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Initials _____

. CROWNS, BRIDGES AND CAPS - I understand that with cracked or fractured teeth, there can be pulp (nerve) damage to the tooth. After the crown placement there can be sensitivity to cold, biting pressure, and tenderness to the gums. The cracked tooth may possibly abscess, needing root canal treatment, or it may be split and need to be extracted. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size & color) will be made before cementation.

Initials _____

6. ENDODONTIC TREATMENT (ROOT CANAL) - I understand that many factors contribute to the success of nerve treatment and cannot be determined in advance. Some of these factors are: my resistance to infection, the location and shape of the canals in the tooth, adjacent nerve involvement, amount of infection, etc. I further realize that there is no guarantee that a root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root canal which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following a root canal treatment (apicoectomy).

Initials _____

7. MINORS/CHILDREN - I agree to be physically present on the premises throughout my child's visit, should the doctor need to ask questions about my child's treatment or to get my permission to make changes in my child's treatment.

Initials _____

8. PERIODONTAL/AMT THERAPY - I have been informed that the purpose of periodontal therapy is to treat my periodontally diseased gum tissues. Due to individual pathology and bone loss, there exists a small risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the best periodontal care. I am aware of possible complications and post-treatment risks which may include, but are not limited to: swelling, discomfort or infection in the mouth, restricted mouth opening, esthetic changes such as increased tooth length exposing crown margins and gum recession (shrinkage), sensitivity to hot or cold for days, weeks, or occasionally months. I understand that long-term success depends on my long-term continued performance of excellent oral hygiene and plaque removal and my availability for regular recare visits.

Initials _____

9. PREMEDICATION/SEDATION - I understand that sedation or premedication involves risks and hazards, including drowsiness, disorientation, impaired motor skills, impaired judgement, mental cloudiness or confusion, nausea, and allergic or drug reaction. However, I request the use of sedation for the relief of and protection from pain during my visit. If the patient is a child, I agree to monitor the child for 6-8 hours following the operative visit and will not subject the child to any situation where impaired motor skills or drowsiness could cause possible danger to the child.

Initials _____

I understand that medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle, automobile or hazardous devices or machinery or work while taking such medications, and/or drugs, or until fully recovered from the effects of same. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from the office if I am sedated.

Initials _____

I have not taken any substance of abuse (drugs, legal or illegal; alcohol; narcotics; amphetamines, diet pills, etc.) that are unknown to the doctor. I also am not taking any medications from my physician that I have not disclosed to the doctor. Furthermore, I do not have any physical or psychological conditions that I have not disclosed to the doctor.

Initials _____

I agree to cooperate completely with the recommendations of the doctor while under his/her care, realizing that lack of same could result in less than optimal result. I realize that dentistry is not an exact science and that reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

Initials _____

_____ _____

Doctor's Signature Patient or Responsible Party Signature

_____ _____

Date Signature of Witness