

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I authorize the dentist to release to hospital or health care service plans, or insurance companies, any and all information and records including x-rays about my medical history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claim for benefits.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

INITIALS \_\_\_\_\_

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received the notice of Privacy Practices and I have been provided an opportunity to review it. The practice has a provision that it reserves the right to change the terms of its notice.

INITIALS \_\_\_\_\_

**DENTAL MATERIALS FACTS**

I have received a copy of the Dental Materials Fact Sheet as required by law.

INITIALS \_\_\_\_\_

**SUBMISSION OF CLAIMS AND YOUR FINANCIAL RESPONSIBILITY**

I authorize the practice to submit claims for payment for services to my insurance companies or health care service plan on my behalf and in my name. I authorize and request the insurance company to pay directly to the dentist. I am responsible for knowing my benefit coverage. I understand that my insurance is an agreement between my insurance company and me. All estimates given to me are NOT a guarantee of payment by my insurance company. It is my responsibility to pay any deductibles, co-payments, or any other balance not paid by my insurance company. Dr. Taddey's office requires my estimated portion at the time treatment is rendered.

I understand that the practice will make every effort possible to assist me with my insurance coverage. Dr. Taddey's office allows no more than 90-days for the insurance to submit payment. Any outstanding claims past the 90-day mark will be my responsibility. If the insurance submits a payment following the deadline, this office will reimburse me or credit my account. I understand that my dental insurance carrier may pay less than the estimate I was given and I understand that I am financially responsible for any charges not covered by my insurance benefits. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

INITIALS \_\_\_\_\_

**CANCELLATION / MISSED APPOINTMENTS**

I understand that should I need to cancel an appointment time reserved specifically for me, I will notify Dr. Taddey's office 48 hours / 2 business days in advance so that my time may be utilized by another patient and we can keep our costs down. If I fail to give a minimum of 48 hours / 2 business days notice, I will be required to pay a fee of \$60 before a new appointment will be made for me.

INITIALS \_\_\_\_\_

**AUTHORIZATION FOR USE OF IMAGES**

I understand that Dr. John J. Taddey may take video or still images of the work that he is doing. I consent to my dentist, or a representative of his staff, taking these images. I understand that these images may be used for the purpose of education, publicity, promotion, and advertising. I understand that I will receive no compensation for such use.

INITIALS \_\_\_\_\_

**INFORMED CONSENTS**

- Examination and X-rays:** I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. INITIALS \_\_\_\_\_
- Changes in Treatment Plan:** I understand the recommended treatment and I am financially responsible. I understand I am no way obligated to any treatment. I also acknowledge 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 examination. I give my permission to Dr. Taddey to make any/all changes and additions necessary. INITIALS \_\_\_\_\_
- Drugs and Medication:** I understand that antibiotics, analgesics and other medications can cause allergic reactions, such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that occasionally, upon injection of local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation in the area of injection. INITIALS \_\_\_\_\_
- Temporomandibular Joint Dysfunction (TMD):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility. INITIALS \_\_\_\_\_
- Cleaning:** Teeth should be cleaned at least 2 times a year. In some cases more frequent cleanings are necessary to insure healthy gum tissue. If a patient has not had regular check ups or on some medications, heavy calculus can build up causing deep pockets in which a gross debridement may be needed along with periodontal scaling and root planing. INITIALS \_\_\_\_\_

Name of Patient \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Relationship to Patient \_\_\_\_\_