CONFIDENTIAL

PATIENT CONSENTS & POLICIES

Print Patient Name _____

PATIENT HEALTH INFORMATION CONSENT & PRIVACY POLICY ACKNOWLEDGEMENT

_____ *(Patient initials)* **Notice of Privacy Practices:** I acknowledge that I have received the practice's Notice of Privacy Practices. I understand that I may contact the person named in the Notice if I have questions about the Notice.

_____ *(Patient initials)* **Release of Information:** I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its privacy practices as described in its Notice of Privacy Practices. I may obtain a copy of the Notice of Privacy Practices, including any revisions of that notice, at any time by contacting: Dr. Roy Northcutt | Phone: 217-839-2135 | Address: 709 Staunton Road Gillespie, IL 62033.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Right to Revoke: I understand that I have the right to revoke this consent at any time by giving written notice to the contact person listed above. I understand that revocation will not affect any action you took in reliance on this consent before you received my revocation, and that you may decline to treat me or to continue treating me if I revoke this consent.

Designation for Release of Information: I authorize release of my medical/dental information to the following individuals:

_____ _____
Name Relationship

_____ _____
Name Relationship

X _____ _____
Patient Signature (Parent or Guardian) Date

Relationship to Patient: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ An emergency situation prevented us from obtaining acknowledgement

☐ Communication barriers prohibited obtaining acknowledgement ☐ Other: _____

COVID-19 PANDEMIC NOTICE & ACKNOWLEDGEMENT OF RISK FOR DENTAL TREATMENT CONSENT

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures can create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and team, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctor and team at all times.

Patient Acknowledgement

I acknowledge that I have read the notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have exposure to COVID-19 from outside this office and unrelated to my visit here.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- ○ Fever
- ○ Shortness of breath
- ○ Dry cough
- ○ Runny nose
- ○ Sore throat
- ○ Loss of taste or smell

I agree to contact the dental office to report if I develop any new signs or symptoms of COVID-19 within the next 14 days.

X _____ _____

Patient Signature (Parent or Guardian) Date

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. At Smiles Plus Dental Care, we are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality dental care you need or desire. Our fees are based on the quality materials we use and the time, effort and skill required in performing your necessary treatment. We are sensitive to your financial circumstances and will do everything in our power to help you achieve optimum oral health.

It is our policy to have a definite agreement between you and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment please ask our Front Office Manager for an approximate cost **prior** to treatment. **Payment for services is due at the time services are rendered unless prior financial arrangements have been made**.

We realize that every person's financial situation is different. As a result, we offer the following payment options:

1. **Cash, Check, Debit or Credit Card** (all major credit cards accepted): We are happy to offer a 5% courtesy discount for all treatment that is paid in full on day of service with cash or check. (Checks returned unpaid to our office from your financial institution are subject to a $35 return fee.)
2. **Interest-Free, In-House 3-Month Payment Plan:** Under certain situations, for treatment or balances over $500, our office may agree to divide your payments equally over a 3-month period with the first payment due at time services are rendered, second payment due 30 days after day of treatment and final payment due 60 days after treatment.
3. **Interest-Free Credit Line*:** Should you be interested in a payment plan, our office uses ***CareCredit®*** and can charge your balance to your approved CareCredit® account for 6 or 12 months interest free on treatment plans in excess of $200.
4. **Extended Payment Plans*:** CareCredit® also offers 24, 36, 48 and 60 month payment plans with competitive rates and no pre-payment penalty.

   ***** We require that you complete a CareCredit® application and be approved for a line of credit prior to the start of your treatment. Please ask for more information about CareCredit®.

Patients with Dental Benefits: As a courtesy to our patients, we will help you process all dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance provider for detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Furthermore,

- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payments directly to our office and authorizes the release of any information concerning your (or your dependents') health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- You must pay the deductible, co-payment and co-insurance, which is the estimated amount, not covered by your insurance company, at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you may be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by parent or legal guardian: The parent or legal guardian accompanying a minor who has consented to treatment is responsible for full payment at time of service. **Unaccompanied Minors:** The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

Delinquent Accounts: Account balances 60 or more days overdue are subject to a finance or late fee under this agreement. Balances remaining after 90 days may be sent to a third party collection agency. As the guarantor of this account, you are personally liable for any and all attorney fees, collection fees and court costs incurred in the collection of a delinquent account.

X _____ _____

Patient Signature (Parent or Guardian) Date

APPOINTMENT POLICY

Smiles Plus Dental Care will work with you to schedule appointment times that are convenient for you. We will respect your time and will run on time all day, every day, to the best of our ability. When we set up an appointment, a specific amount of time is reserved especially for you. **Our office requires 24 business hours' notice if you need to change or cancel your appointment**. We reserve the right to charge you up to $25 for a broken or missed appointment without 24 business hours' advance notice. And, multiple broken appointments may result in being dismissed from our dental practice.

Late Arrival: When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late, it decreases our ability to accomplish this. If you arrive more than 10 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens, it will be considered a broken appointment.

MEDIA RELEASE CONSENT

I authorize you to use my name, picture and/or story for marketing purposes via the press, Facebook and/or Smiles Plus Dental Care's website.

COMMUNICATION and CONSENT

Communications with You: By signing below, you are authorizing Smiles Plus Dental Care to call you at any number you provide including calls to work, home, mobile or similar device for any lawful purpose regarding your account.

Consent: I have read, understand and agree to abide by the above terms and conditions. I understand the Financial Policy and Appointment Policy.

I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I authorize the use of my signature on all insurance submissions. Additionally, by signing this form, I authorize Smiles Plus Dental Care to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.

X _____ _____

Patient Signature (Parent or Guardian) Date

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Relationship to Patient