North MS Periodontics & Implant Dentistry, PLLC

General Consent Form

PATIENT NAME: ____DOB:________________DATE:_____________

CONSENT FOR TREATMENT

I, hereby authorize Dr. Mike Robertson, D.M.D., or Endodontist, or Certified Registered Nurse Anesthetist or any one he may designate to perform treatment for my periodontal/dental needs. I authorize the clinic to take x-rays/photographs. I release J. Michael Robertson and his employees from any liability in the making and use of these requested x-rays or photographs. I also understand that I will be billed direct for those services provided by other health care providers to whom I am referred, such as anesthesiologists, endodontics, general dentists, etc**. *I am aware that the practice of periodontics is not of exact science and I acknowledge that no guarantees have been made as to the results of treatments or examinations in this clinic.*** (_____)

RELEASE FROM RESPONSIBILITY

If I should leave the clinic against the advise/protocol of the doctor prior to treatment being completed, I hereby relieve said doctor/assistant/nurse and the clinic of all liability for my action.
No guarantee, warranty, or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, a risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment and may require retreatment and/or extraction of teeth.
However, it is Doctor's opinion that therapy will be helpful, and that the further loss of supporting tissue or bone would occur sooner without the recommended treatment. (_____)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the clinic's designee to release to the payors/insurers herein specified to any dental insurance, medical insurance, or to any other insurer agency concerned with the payment of my charges, any and all information, by phone, mail, fax, email, or electronic mail, including copies of records, and any and all medications information, related to our services which are deemed by the payors/insures or other agencies, to be required in the processing of applications for financial coverage for services rendered. I authorize these intermediaries to pay direct to North MS Periodontics & Implant Dentistry and/or J. Michael Robertson, D.M.D. I also authorize release of my medical records to any other health care, dental care providers, or third parties consulted by my periodontist. (_____)

I authorized the listed names below to receive my patient information concerning my well-being, called in case of emergency, collection of payment and any other circumstances that could arrive at the Doctors' discretion.

NAME, ADDRESS, PHONE NUMBER:

1.____relationship_____________

2.____relationship_____________

3.____relationship_____________

I, ____________________________, understand 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.

____

******I RECIEVED AND READ A COPY OF OFFICE'S NOTICE OF PRIVATE POLICY.******

SIGN:____DATE:_______________

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PATIENT NAME:____**DOB:**_______________**DATE:**____________

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible to the clinic for all charges not covered or not paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, self insured health plans or other third party payor are due and payable upon services based on the best estimates available as determined by North MS Periodontics & Implant Dentistry. Charges remaining on this account are payable upon demand. It is also agreed that in case of default of payment and this account is placed in the hands of a collector or attorney for collection or suit, all reasonable collection fees, reasonable attorney fees, cost and other expenses will be paid by the undersigned. (___)

Periodontal Treatment, Laser Therapy, LANAP, LAPIP, I.V. Sedation

I have been informed that other possible alternative methods of treatment include pre-surgical therapy only: Root planing followed by periodic recalls and maintenance therapy only. I consent to the administration of such anesthetics as may be considered necessary or advisable by the periodontist responsible for this service. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgement or the procedures in addition to or different from those he contemplated, I further request and authorize the doctor to do whatever he may deem advisable. (___)

The purpose of my treatment is to surgically treat and possibly correct my periodontal diseased gums and their supporting bone. **The primary responsibility for prevention of loss of teeth falls upon us as individuals**. **Periodontal disease is prevented by complete daily removal of plaque from the teeth**. I have been shown how to accomplish this. (___)

I am aware that the long term success of treatment requires my cooperation and performance of daily removal of bacterial deposits (plaque) from my teeth, as well as periodic periodontal maintenance therapy after the proposed treatment at a dental office or my periodontal office. (____)

Although the outcome of periodontal therapy is predictable and increases lifetime of the teeth, a particular tooth or teeth may be lost in time as a consequence of certain factors in the mouth, such as occlusal forces or poor hygiene. I further understand that if no treatment is rendered, my present periodontal condition will probably worsen in time, which may result in premature tooth loss. I have been advised of the risks of this procedure which may include loss of blood, infection, longer appearance of teeth, discomfort, restricted mouth opening for several days or weeks, interference with phonetics, increased tooth looseness, food impacting between teeth after eating and root sensitivity. I understand that if intravenous sedatives have been used, a responsible adult must escort me home and should not operate machinery until the next day. If I receive intravenous sedation, I understand that I may experience tenderness and bruising at the injection site. (____)

I have read the above consent and various releases, assignments of benefits and agreement for payment of charges and herewith execute the same voluntarily. A copy of this document shall be as valid as the original.

____

Patient Signature (and/or guardian responsible) Date (required)

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Doctor/Assistant Witness (required) Date (required)