SPOTLIGHTDENTAL
Go Ahead.. Smile!

GENERAL OFFICE POLICIES AND EXPLANATIONS

We are pleased you have chosen our office for your oral healthcare and we are committed to providing the highest level of treatment and customer service in dentistry. If there is any way we can improve what we do please let us know. Below are a few areas of agreement we address before we accept new patients and perform any dental treatment.

General consent for treatment – We are a dental office performing evaluation and treatment for oral health problems. Generally, and with your consent, we will perform procedures ranging from normal hygienic cleanings to restoration or replacement of missing teeth. We want you to know the following:

1. We will use **radiographs** (x-rays) of your teeth and tissues to discern the presence of disease conditions in your bony or calcified tissues. These radiographs are a necessary part of our diagnostic examination. Our normal frequency is bite-wing radiographs once per year during regular examination and a panoramic radiograph once per five years. Other radiographs will be taken as needed to document the presence or progress of any disease condition you experience.
2. Our procedures may at times require the use of **local anesthetics** to numb your teeth and tissues to allow your greatest comfort during care. Dental anesthetics on rare occasion involve some bruising of involved tissues and may very rarely have an adverse effect of prolonged or permanent anesthesia. Sometimes medications you are taking – either prescribed, over-the-counter, or herbs or supplements – may have an adverse interaction with anesthetics. Please let us know if you are taking over-the-counter medications, herbs, or supplements.
3. As in any healthcare environment there may be **adverse effects** or unanticipated needs which apply to the particular treatment you are undergoing. These effects may or may not be limited to other adjunct procedures related to but unanticipated at the time of diagnosis (such as root canal, crown lengthening, or placing a crown instead of a large filling), temporary or long-term discomfort or sensitivity due to placement of a restorative material, or in rare cases the treatment prescribed and performed may not have the intended effect. We will make every attempt to anticipate and/or correct any unforeseen situations. We may at times elect to refer you to a dental specialist that performs the necessary procedure. Please ask questions and understand each procedure before it is performed.
4. At times, **pictures** of your teeth and smile may be used to communicate with various laboratories or treatment specialists to obtain the highest level of care available. We want you to know these pictures will be used in only this way unless otherwise specified in another agreement.
5. **Additional informed consent** will be required before we perform procedures involving teeth which require root canal therapy or extractions.

Business Transactions – Please fully understand each of the following:

1. We accept cash, personal checks, Visa, MasterCard AMEX or Discover. We offer a 5% accounting adjustment for cash or check paid at the first appointment of a treatment plan where the total fee exceeds $800. Returned checks are subject to a $25 charge. Outside partners are available to arrange short-term financing of your dental treatment. Please ask at the front desk for details.
2. As a courtesy, our patients 55 and older receive a standard 5% accounting adjustment on all fees.
3. Your dental insurance is an agreement between you, your employer and the insurance company. Your plan is not designed to cover every expense associated with prescribed treatment. It is your responsibility to know your insurance contributions prior to treatment. You are responsible for any remaining fees associated with your treatment after insurance contributions are made.
4. Our office will file and accept benefits from your insurance company as a third-party payee described in your insurance agreement. We will help you determine how your maximum insurance contribution applies to your recommended treatment. If an insurance estimate is required at any time, please let us know immediately. We will occasionally ask your participation in this process.
5. You agree at the end of each appointment to pay for your estimated portion of treatment as indicated by our front-desk.

6. Insurance estimates will be submitted for the following procedures before the start of any definitive treatment: single or multiple crowns, bridges, implant crowns, and advanced periodontal procedures such as scaling and root-planing (SRP). If you elect to continue treatment before these insurance estimates are made, you assume responsibility for the full fee associated with the procedure.
7. Payment will be made at the end of the appointment for adjunctive materials such as electric toothbrushes, prescribed mouth rinses, high-fluoride toothpastes, or placement of periodontal antibiotics. Insurance codes will be filed but please understand the design of most benefit plans does not allow for the payment of these procedures.
8. Elective cosmetic treatment performed will be paid in full and in advance of the first appointment; any insurance contribution will be filed for payment directly to the patient.

Private Health Information – As of April 2003 the Health Information Portability and Accountability Act (HIPAA) is in effect and we want you to know that we take this seriously. Our office is HIPAA compliant when handling your private health information. We may at times be required to electronically transmit your health information related to insurance claims or in association with treatment in conjunction with another healthcare provider or interested party. Our record systems are secure and we make every effort to monitor and protect the distribution of any of your sensitive private health information. If you are uncomfortable at any time with the possibility that information we discuss with you in the office will be overheard, please notify us and we will make arrangements for a private discussion. We will not at any time, without your consent, share any private health information with others. To review the complete HIPAA compliance statement see our front desk.

Please ask for clarification if needed

We are looking forward to seeing you regularly in our office and anticipate the referral of your friends and family based on your experiences. At any time if there is something we can do to make your visits with us more enjoyable please let us know.

I understand and agree with each of the above items and have had an opportunity to ask questions and get further information related to each of these areas. I understand that I can choose to have my dental healthcare performed at another office if I do not agree with these statements.

______________________________ (s) ______________________
Date

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