HUEBNER DENTAL GENERAL CONSENT

Consent to Treatment

I have presented myself to this facility for dental care and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. I realize I have the right to refuse any treatment or procedures to the extent permitted by law. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment), oral surgery, fixed and removable prosthodontics (crowns, bridges, and dentures), restorative dentistry, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Notice of Privacy Practice

By signing this form, I acknowledge that Huebner Dental has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and /or any questions I have concerning this Privacy Notice with Huebner Dental. **The Notice of Privacy is available in our website and a paper copy can be requested at any time.**

Patient Benefits Provided by Your Insurance Company

I acknowledge that my dental benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/ or coinsurance. I acknowledge that I should contact Huebner Dental if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment. I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I acknowledge that I am responsible for any balance not covered by my insurance and that I have the right and responsibility to follow-up with my insurance for specific questions regarding my individual policy.

I authorize the use of my signature on file for all insurance submissions Yes ____ No _____

Cancellation Policy

Huebner Dental require a 24 hours cancellation notice upon cancelling an appointment. If prior notice is not given, you will be charged in full for the missed appointment. The Fee applied will be $50.00

Communication

I consent to receive information; such as appointment reminders, patient surveys, and other information relating to my dental treatment via phone, text and email provided.
Your email address will be kept confidential and will be not shared.

Please reply to the text or email confirmation. Appointment confirmation is required to keep your appointment.

The cell phone number I authorize is: _____

The email address that I authorize is: _____

Release of information

I authorize the following individual to receive information regarding my diagnosis, treatment, and billing
Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I acknowledge, as indicated by my signature bellow, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the information release to receive my health information.

Patient Name (Please print): _____

Patient or Guardian Signature: _____

Date of Authorization: _____