Consent for Treatment

By state law we are required to make an attempt to inform patients of possible complications, even though rare, which could result from anesthesia, local anesthesia, and/or sedation.

- Allergic reactions which could require hospitalization
- Cardiac arrest, which could result in brain damage or even death

It must be understood that these types of complications are extremely rare and every possible precaution will be taken to prevent their occurrence as well as to treat them successfully should they occur.

The most common, even though rare, complications resulting from tooth extractions, periodontal therapy, cyst removal, biopsies, fillings, root canal therapy, crowns, veneers, bridges, etc, are:

- Bleeding heavy enough to stop therapy
- Injury to adjacent teeth and fillings
- Post-operative infection requiring additional treatment
- Possibility of a small piece of root being left in the jaw when its removal would require extensive surgery, or other complications
- Fracture or breakage of the jaw
- Post-operative discomfort and swelling which may necessitate several days of home recuperation
- Stretching of the corners of the mouth resulting in cracking and bruising
- Nerve injury, sensory and/or motor, adjacent or on the other side of the surgical site, especially underlying teeth resulting in numbness of the palate, lips, tongue, chin, face, or other anatomical structures in the head and neck
- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery
- Tooth sensitivity, which may require additional treatment
- Tooth mobility
- Recession of the gingival (gums)

Photographic Release

I grant authorization to Dr. Ron Bell to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides and or/ videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television, etc.) and professional publications (dental magazines and journals). I do not expect compensation, financial or otherwise, for the use of the photographs, slides, and/or videos.

Broken Appointment Policy

We sincerely value your time and expect you to value ours as well. It is your responsibility to arrive on time for each appointment scheduled. As a courtesy to you, we offer appointment reminder calls, emails, and/or text messaging. You must notify this office at least **24 hours in advance** of your appointment if you need to cancel or reschedule. This allows us time to place another patient in your reserved appointment time. We reserve the right to charge a $25 fee for each missed appointment without prior notice.

Financial Agreement

We appreciate you allowing us to provide dental care for you and your family. We wish to attract patients and families to our practice that take an active role in their oral health. Because we value our relationship with you and believe the best relationships are based on understanding, we offer these clarifications on methods of payment and insurance reimbursement.

- If you have dental insurance, please bring your insurance card to all appointments and notify us of any changes.
- As a courtesy to you, we will file insurance benefits for you. Many insurance companies will pay our office directly on your behalf. However, some insurance companies may only reimburse you and not our office. If your insurance company will not reimburse our office directly, you will be responsible for the full cost of the visit at the time services are provided.

- Any amount determined not to be covered by your insurance company is payable at the time services are rendered. These fees may include: deductibles, co-payments, and fees not covered by your insurance company.
- We will allow a maximum of 45 days for your insurance company to clear account balances. After this period, any unpaid portions will be due in full by the patient or person financially responsible.
- Methods of payment: Cash, Credit cards, Debit cards, Money orders, and Personal checks (returned check fee of $35).
- Financing Programs: We do not offer in-house financing. However, we do offer a long and short term financing program available through a third party. Please inquire about this for further information regarding this program.
- Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we ESTIMATE insurance coverage to be, and your estimated financial obligation due on the day of the service provided. **This figure is only an ESTIMATE!** Additional billing or refunds may be required. Any differences will be brought to your attention as soon as possible. If a balance remains on your account with in 30 days of our billing cycle, a late charge of 1.50% will be assessed each month.
- Financial Obligation: After attempts to collect outstanding funds and a 60 day grace period from the time of service, patients or person financially responsible not fulfilling their obligations will be turned over to collections.

I,_____, hereby acknowledge that I have read and agree to the information stated in these forms, including the Consent for Treatment, Photographic Release Policy, Broken Appointment Policy, and Financial Agreement Policy. I furthermore understand that it is my responsibility to maintain communication with this office by updating my contact information, including phone numbers, addresses, and employment record. By signing below, I agree to all information aforementioned in these agreements and consents.

Patient or Patient Guardian Signature_____ Date_____

We look forward to working with you to maintain your optimal oral health! Thank you for being our patient, we're glad you're here!