Carothers Family Dental, PA ~ General Dentistry

310 Stagecoach Trail #700 - San Marcos, Texas 78666
smtxdental.com 512-396-4288

Patient's Name: _____ Birth date: _____

I give consent for myself/my child to receive dental treatment by all dentists practicing at Carothers Family Dental, PA. These procedures include, but are not limited to: examinations, oral prophylaxis (cleaning), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns and bridges), periodontal (gum) treatments, endodontics (root canal) treatments, extractions, and the use of local anesthetics.

I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, and/or prolonged/permanent anesthesia.

I understand that, the doctors and the office staff want me to understand the state of my dental health, my treatment needs, potential complications, and the cost of maintaining my dental health and will communicate these things to the best of their ability. I know that I may ask for any clarification necessary to help me understand any recommended treatment, treatment options, potential complications of treatment, and the cost of treatment. I also understand that I certainly may refuse any recommended treatment for my child or me.

_____ _____

(your signature, if signing for yourself) (date)

_____ _____

(print your name, *if signing for a minor*) (relationship, *if signing for a minor*)

This section is to be completed for children under the age of 18 by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above-named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental appointments:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please check one:

_____ I believe my child is mature enough to receive dental treatment unaccompanied by an adult. I understand that no invasive treatment, such as extractions or the initiation of root canal therapies, will be performed unless I am notified by telephone, and that it is my responsibility to keep a current phone number on file for immediate contact. If I cannot be reached in an emergency, I give permission to perform whatever therapies the treating provider deems necessary.

Phone number: _____ alternate number: _____

____ I desire my child to always be accompanied by myself or one of the individuals named above.

_____ _____

(signature of parent or legal guardian) (date)

This consent shall be considered in effect until rescinded or revoked.

Revised 2021-05

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Our Policy of care and payment

Ensuring that our patients receive high quality care is the goal of our practice.

When the type of treatment has been decided upon, time will be appointed for the most efficient and earliest possible completion of the case. Financial arrangements are customarily made at this time. We want to be concerned with your dentistry, not financial responsibilities.

Payment options:

Please indicate below the form of payment you choose to settle your account:

☐ Cash or check

☐ Major credit card

☐ Automatic Monthly billing to your Major Credit Card

☐ Guarantee any amount not covered by insurance with Credit Card

☐ Care Credit (*subject to credit approval*) *Applying for care credit only takes a few minutes and there is no fee to apply. If credit application is declined, another form of payment listed above is required.*

Authorization and release:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay, directly to the dentist, dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services.

I agree to be responsible for payment of all services rendered on my behalf or my dependent's.

_____ _____

Signature of patient / responsible party date

Note to patients with insurance:

Please be aware that some companies pay a fixed allowance for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance, or any other balance left unpaid by your insurance company. We will help you by filing your dental insurance claims. We can only estimate your benefits. Payment of patient's portion is due at the time service is rendered. All remaining portions will be the patient's responsibility.

_____ I have read and understand all charges are my responsibility, even if I have dental insurance.

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Acknowledgement of receipt of notice of privacy practices

*** You May Refuse to Sign this Acknowledgement ***

I have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

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.
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ Other (please specify)

_____
_____

Revised 2021-05