ALWAYS A SMILE

Ronald M Olszewski, DDS
Acknowledgement of Receipt of Notice of Privacy Practices

PATIENT NAME_____ PATIENT **DATE OF BIRTH**____/____/_____

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Always A Smile Privacy Practices on the date indicated. If you have any questions regarding the information in the Always A Smile Notice of Privacy Practices, please do not hesitate to ask us.

SIGN_____ **DATE** _____

Patient or Representative

HIPAA Release of Information Authorization

[ ] I authorize the release of information including the diagnosis; records of treatment rendered to me and claims information. This may be released to (*please print*):

_____

NAME AND RELATIONSHIP

[ ] Information is not to be released to anyone with the exception of what is necessary for insurance claim payment.

This RELEASE OF INFORMATION will remain in effect until terminated by me in writing.

SIGN_____ **DATE**____/__/____

Financial Policy

Prior to providing treatment, the recommended treatment options and costs will be discussed. If requested, we can complete a pre-treatment estimate with insurance, please keep in mind insurance companies do not guarantee benefits when we verify coverage. You may still receive a bill once insurance pays their portion; you are responsible for any outstanding balance after insurance. Payment is due at time of service by cash, check, all major credit cards, and care credit which can be applied for online. Appointments are necessary and failure to notify us of cancellation within 24 hours may result in a $30.00 failed appointment fee. Continued failure to keep appointments may result in discontinued care. It is your responsibility to update any changes to your insurance coverage, address, and contact information.

I have read and agree to the above financial policy.

SIGN_____ **DATE**____/____/____

GENERAL DENTISTRY INFORMED CONSENT

Patient:_____ Date:_____

1. **WORK TO BE DONE:** I understand that I may be having the following work done: Exam, X-rays, Fillings, Cleaning, Fluoride, Scaling & Root Planing, Sealants, Space Maintainer, Night Guard, Pulpotomy, Crown, Bridge, Veneers, Reline, Partial, Denture, Bleaching, or any other needed treatment.
2. **DRUGS AND MEDICATION:** I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock.
3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.
4. **PERIODONTAL LOSS (TISSUE AND BONE):** I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to loss of my teeth or a dental infection. Alternative treatment plans have been explained to me, including gum surgery, replacements and /or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition.
5. **FILLINGS:** I understand that care must be exercised in chewing on fillings, especially amalgam fillings during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. Sometimes a very deep filling may need a root canal or extraction at a later date.
6. **CROWNS, BRIDGES, AND VENEERS:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the final crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or veneer (including shape, fit, and color) will be before cementation. It is also my responsibility to return for final cementation within 21 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or veneer. I understand that there will be additional charges for remakes due to my delaying final cementation.
7. **DENTURES, PARTIALS, AND RELINES:** I understand that wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (dentures placed right after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A reline usually is required 3 months to a year later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep my delivery appointment may result in poorly fitting dentures.

   INFORMED CONSENT: I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I hereby authorize any of the dentists/dental auxiliaries to proceed with and perform the dental restorations/treatments as explained to me. I understand that my treatment plan is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment.

Signature of
Patient/Guardian_____Date_____