CONSENT FOR TREATMENT FORM

Privacy Practices

THIS NOTICE DECRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability act of 1996 (HIPAA), we are required to maintain the confidentiality of your health information. This describes how we may use and disclose your protected health information to carry out treatment, payment of health care and for other purposes that we are permitted or required by law. We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health/dental information may be provided to a dentist to whom you have been referred. In addition, we may disclose your protected health information periodically to another dentist, physician, or health care provider who becomes involved in your care, including the use of photo imaging. We may use and disclose information about you in order to obtain payment for services rendered. Such disclosures may be made to you, responsible party or third party.

RESIDENT/PATIENT INFORMATION

*Name _____ Birthdate _____

*Name of Community _____ ☐ MEMORY CARE ☐ ASSISTED LIVING ☐ INDEPENDENT

*Room Number _____ Residents Email (If applicable) _____

Name of Physician _____ Physicians Phone Number _____

Name of Dentist (If applicable) _____ Dentist Phone Number _____

Is patient required to take antibiotic before dental treatment: ☐ Yes ☐ No

If YES, reason for premedication _____ Year of surgery _____

Allergies _____

Check if resident has any of the following:

☐ Artificial Heart Valves ☐ Artificial Joints ☐ Taking Blood Thinner Medication

☐ Recent Heart Attack or Stroke? Date _____

Any medical condition or medical/dental information that we should be aware of before dental treatment?

_____

***Name of Responsible Party** _____ *Phone _____

*Relationship to Resident _____ *Email _____

(Please print clearly)

*Mailing/Billing Address _____

Preference for future dental care frequency: ☐ 3 month ☐ 6 month

Would you like us to send you an itemized statement with the ADA codes and information about self-filing for dental insurance reimbursement? ☐ Yes ☐ No

The dental hygiene assessment along with recommendations and/or referrals will be emailed to the responsible party after services are completed. Please allow up to 48 hrs._____ (Initials)

FEES (Please read)

By signing this consent form you are agreeing that all fees are ultimately the responsibility of the "Responsible Party." Payment is due before or at the time of dental services, unless other arrangements have been made with Senior Smiles or the community beforehand. If so, by signing this consent form you agree to pay Senior Smiles no later than 14 days from the date of services.
By signing this consent form you ackowledge that Senior Smiles does not directly bill dental insurers and cannot guarantee supplemental dental benefit coverage.

SIGNATURE OF RESPONSIBLE PARTY

I hereby give my consent for Senior Smiles/Marietta Roswell Dental Care to use and disclose protected health information to carry out treatment, payment, and health care operations. With this consent, Senior Smiles/Marietta Roswell Dental Care may call my home, cell phone, or other alternative locations and leave a voice mail or an email in reference to the resident and facility listed above as it pertains to their clinical and dental care. I have a right to restrict or revoke my consent in writing except to the extent of disclosures already made in reliance upon my prior consent.

Signature: _____ Date: _____

Thank you for your prompt response.
We look forward to serving your loved one!

Senior Smiles
Marietta Roswell Dental Care
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