BOYLES
General Dentistry
& Implant Center

Disclosure and Consent to Dental Procedures

To the Patient: You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist. Make sure all your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. This disclosure is not meant to scare you. It is simply an effort to better inform you about the nature of the treatment(s) that you may need.

As with all diagnostic, restorative and dental procedures, there are common risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

I agree to the following Acknowledgements:

- EXAMINATION, X-RAYS and PHOTOGRAPHS: I understand that the initial visit may require radiographs and photographs to complete the examination, diagnosis, and treatment plan. These records may be used in dental education. These records are protected by HIPAA.
- 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 teeth that were not discovered during examination—the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions to the treatment plan as necessary.
- DRUGS, MEDICATION, AND SEDATION: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased using alcohol or other drugs. I understand this and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of any anesthetic medication or drugs that may be given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.
- LOCAL ANESTHETIC: I understand that the administration of local anesthesia and its performance carries certain risks, hazards, and unpleasant side effects which are infrequent, but nonetheless may occur. They include, but are not limited to the following: nerve damage or paresthesia, a temporary, increased heart rate and/or a flushed feeling, allergic reaction, hematoma or swelling near or at the injection site, trismus or difficulty opening jaw for a short time after the injection, facial paralysis, soft tissue damage after the dental procedure due to biting of tongue and cheek, or burning tissues with hot food or beverage while still numb, infection, sloughing of tissue, ocular complications and needle breakage.
- FILLINGS: I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.
- PERIODONTAL STATUS AND CLEANING- I understand that I will undergo a periodontal exam via probing to evaluate the health of my gums. Depending on the current health of my gums, I may require a second or deeper cleaning to fully evaluate my dental needs. I understand that my teeth will be cleaned using ultrasonic and hand instruments. This may result in a temporary sensitivity; however, a root canal or extraction may be necessary for abscessed teeth.

- POST-OPERATIVE SWELLING, BRUISING AND DISCOMFORT- Infection may also occur which will require additional treatment and bleeding may be prolonged. There is also a possibility of injury to or stiffness of the neck and facial muscles. This could cause possible changes in occlusion.
- NERVE INJURY, may result in numbness, tingling, or altered sensation of the lips, chin, gums or teeth. Possible damages to the nerves of the tongue leading to numbness or altered sensation. This may include an alteration in taste, although usually temporary, these changes may be permanent.
- TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ): I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) after routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility
- **HEALTH HISTORY**: It is very important that you provide your dentist with accurate information before, during and after treatment. I understand that it is my responsibility to give Boyles General Dentistry an accurate health history. Important Health information to disclose includes:
  - **All medical conditions**
  - **All medications including, prescribed, over the counter or self-prescribed**
  - **Any allergies**
  - **Any infectious disease**
  - **Any heart conditions**
  - **Any use of oral or I.V. Bisphosphonates**

- RECOMMENDATIONS FOR TREATMENT: It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

_____

Date

_____

Patient Name

x_____

Patient Signature

_____

Witness

Authorization to Disclose Protected Health Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and state law must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Individuals cannot be denied treatment based on a failure to signed this authorization form and refusal to sign this form will not affect the payment, enrollment or ellgibility for benefits.

Full Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Cell/ Alternative Phone: _____ Email: _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/ Organization Name: Boyles General Dentistry & Implant Center
4305 N Garfield Dr. St 225
Midland State: Texas Zip Code: 79705
Phone: (432)-685-7011 Fax: (432) - 687- 3763

WHO CAN RECEIVE AND USE HEALTH INFORMATION?
Person/ Organization Name: Boyles General Dentistry & Implant Center
4305 N Garfield Dr. St 225
Midland, Texas 79705
Phone: (432)-685-7011 Fax: (432) - 687- 3763

REASON FOR DISCLOSURE
(Choose only one option below)

- ☒ Treatment/ Continuing Dental Care
- ☐ Personal Use
- ☒ Billing or Claims
- ☒ Insurance
- ☒ Legal Purposes
- ☐ Disability Determination
- ☒ School
- ☒ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released check only the first box.

- ☒ All health information
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/ Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/ Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/ Cadiology Reports
- ☐ Other _____

EFFECTIVE TIME PERIOD. this authorization is valid until the earlier of the coccurence of the death of the individual; the inividual reaching the age of majority; or ermission is withdrawn; or the following specific date (optional)"

Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understant thatI can withdraw my permission at any time by giving the written notice stating my intent to revoke this authorization to the person or organiztion under "WHO CAN RECEIVE AND USED THE HEALTH INFROMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this forma and agree to the uses and disclosures of the information as described. I understan that refusing to sign this form does not stop disclosure of health information that has occurred prior to the revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosure to cover entities as provided by HIPAA and state law. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.

SIGNATURE X _____ _____

Signature of Individual or Individual's Legally Authorized Representative DATE

Printed name of Legally Authorized Representative (if Applicable): _____

If representative, specify relationship to the individual __ Parent of minor __ Guardian __Other:_____

Acknoledgement of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Patient Name:	Date of Birth:

This consent form allows Boyles General Dentistry & Implant Center to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Boyles General Dentistry & Implant Center has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Boyles General Dentistry & Implant Center.

_____ Initial — I hereby authorize Boyles General Dentisty & Implant Center to use unsecured email and mobile phone text messaging to trasmit to me the following protected health information: 1) Information related to the scheduling of appointments; and, 2) Information related to billing and payment.

_____ Initial — I hereby authorize that Boyles General Dentisty & Implant Center may leave messages on my voicemail to confirm appointments, and/ or may speak with other members of my household and leave messages with them regarding my appointments.

___ Email ___ Home Phone ___ Office Phone

_____ Initial — I hereby authorize that Boyles General Dentistry & Implant Center may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the office while I meet with my dentist and staff.

_____ Initial — I hereby authorize that Boyles General Dentisty & Implant Center may disclose my personal health information to anyone I have listed as my emergency contact.

_____ Initial — I here by authorize that Boyles General Dentisty & Implant Center may disclose my personal health information to the following persons:

Name	Telephone Number	Relationship to Patient

Furthermore, my (or my child's) personal health information may NOT be disclosed to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Boyles General Dentistry & Implant Center services may still use information to complete any action that it began prior to my revoking consent and which may rely on my protected health information. I understand that Boyles General Dentistry & Implant Center may refuse services if I revoke this consent.

I understand I have the right to request - now and in the future - how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understant that while Boyles General Dentisty & Implant Center in not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

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ADA Dental Patient Rights and Responsibilities Statement

Your dentist is the best source of information about your dental health and wants you to feel comfortable about your dental care. Maintaining healthy teeth and gums means more than just brushing and flossing every day and visiting your dentist regularly. As an informed dental patient, it also means knowing what you can expect from your dentist and dental care team and understanding your role and responsibilities in support of their efforts to provide you with quality oral health care.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care, but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

Patient Rights

1. You have a right to choose your own dentist and schedule an appointment in a timely manner.
2. You have a right to know the education and training of your dentist and the dental care team.
3. You have a right to arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.
4. You have a right to adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
5. You have the right to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
6. You have a right to an explanation of the purpose, probable (short and long term) results, alternatives and risks involved before consenting to a proposed treatment plan.
7. You have a right to be informed of continuing heath care needs.
8. You have a right to know in advance the expected cost of treatment.
9. You have a right to accept, defer or decline any part of your treatment recommendations.
10. You have a right to reasonable arrangements for dental care and emergency treatment.
11. You have a right to receive considerate, respectful and confidential treatment by your dentist and dental team.
12. You have a right to expect the dental team members to use appropriate infection and sterilization controls.
13. You have a right to inquire about the availability of processes to mediate disputes about your treatment

Patient Responsibilities

1. You have the responsibility to provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.
2. You have the responsibility to report changes in your medical status and provide feedback about your needs and expectations.
3. **You have the responsibility for full financial obligation to pay for all dental treatment rendered. We are an out-of-network provider, which means that we are not contracted by dental insurance companies. This gives us the freedom to determine our fees. Whatever the dental insurance company does not end up paying, the patient or parent or guardian, is responsible for the total bill.**
4. You have the responsibility to participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.
5. You have the responsibility to inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.
6. You have the responsibility for consequences resulting from declining treatment or from not following the agreed upon treatment plan.
7. You have the responsibility to keep your scheduled appointments.
8. You have the responsibility to be available for treatment upon reasonable notice.
9. You have the responsibility to adhere to regular home oral health care recommendations.
10. You have the responsibility to give 24 hours' notice for cancelling any appointment. If you call and cancel the same day as your scheduled appointment or do not show for your appointment, **we have the right to charge your account a $25 fee non-compliance**.
11. You have the responsibility to assure that your financial obligations for health care received are fulfilled.

Date: _____ Patient Signature: _____