General Consent

Consent for Treatment

I, the undersigned patient, hereby authorize Dr. Charity and/or his associates/hygienists and assistants to perform the treatment they has discussed with me. I understand my dental conditions and treatment options that have been discussed. I understand this treatment may include but is not limited to; anesthesia, fillings, crowns, partials, dentures, extractions, cleanings, scaling and root planning (periodontal therapy), and all other routine dental issues is associated with inherent risks that may include, but not limited to; allergic reaction, infection, bleeding pain, nausea, blood clots, paralysis, stroke, heart attack and death. If I have questions about these risks, I have addressed them with the doctor. I understand the expected results of the procedures but understand the expected results of the procedures but understand that these results cannot be guaranteed. I understand I have the right to waive treatment but also understand the risks of not moving forward with recommended treatment.

HIPPA Consent

Each time you visit the office, a record of your visit is made which contains information about your examination, symptoms, diagnosis, and treatment plan for future treatment. The information in the dental records belongs to you. You have the right to request certain uses and disclosures of your information, inspect the records and request a copy of the records. Our office has the responsibility to maintain the privacy of your information. We may use or disclose information to a family member or another person responsible for your care or payment. We may contact you by phone and/or email to provide appointment reminders. As required by law, we may disclose dental/medical health information to public health or legal agencies charged with preventing or controlling disease, injury, disability, or to law enforcement. If I, the undersigned patient, have further questions about my rights concerning HIPAA, I understand I can request a full HIPAA disclosure.

I give consent for my treatment & financial arrangements to be discussed with _____

Patient Signature: _____ ***Date:*** _____

Insurance Disclosure

Our goal is to help you maximize your dental insurance. As a courtesy, we are happy to submit your dental services to your insurance company. I, the undersigned patient, fully understand that verification of dental benefits is NOT a guarantee of payment by my insurance company and may vary and/or change according to my individual plan. I fully understand that the dental office is only able to give an estimate of coverage and that fees charged are determined by my insurance company and Dentists of Overland has no control over these fees. I also understand that I am fully responsible for any allowed charges that are not covered by my insurance company and I will pay those fees to Dentists of Overland and have the right to seek payment from the insurance company.

Cancellation/No-show Agreement

As a courtesy to all patients, we kindly request 48 business hours' notice of appointment change or cancellation. Otherwise, a fee of $40/hr for Hygiene appointments and $75/hr for treatment appointments with the doctor will be charged. When patients no show or cancel last minute, it does not allow us the opportunity to offer the appointment to a patient on our waiting list.

Effective immediately all appointments longer than one hour, require reservation fee equal to 50% of the estimated portion for that appointment. I have read and understand the above mentioned policies, consents and agreements.

Patient Legal Name (Printed): _____

Patient/Guardian Signature: _____ **Date:** _____