Choice One Dental Care of Cartersville

I hereby grant consent for treatment and/or diagnostic examination at the office of **Choice One Dental Care of Cartersville.** This treatment may not be limited to the following:

Observation and examination of the tissues of the mouth and related structures (for example: tongue, throat, cheeks, probing the gums, etc.)

A. Cleaning of the tooth or teeth or other gum related treatment (for example: gum surgery).
B. Administration of an anesthetic (for example: numbing of the tooth, teeth, or gums).
C. Administration of an inhalation analgesic (for example: nitrous oxide-laughing gas).
D. Extraction of a tooth or teeth (for example: pulling of the tooth or teeth).
E. Filling of the tooth or teeth with a temporary or permanent filling (including crowns, or bridges).
F. Root Canal Therapy (for example: remove the nerve of the tooth).
G. Replacement of missing teeth with a partial/complete dentures, and/or restored implants.
H. Other.

1. I understand all diagnostic aids such as x-rays, photographs, recordings, testimonials, and drawings with may be deemed necessary or desirable may be taken, and will remain the sole property of **Choice One Dental Care of Cartersville.**
2. I understand that this examination **DOES NOT GUARANTEE** further treatment at the office of **Choice One Dental Care of Cartersville.** I understand that anyone with financial interest will be given consent to receive and/all information deemed necessary.
3. Insurance Patients: WE FILE YOUR INSURANCE CLAIM AS A COURTESY. Insurance policy changes must be presented to us prior to your dental appointment. If you policy has been terminated or has a waiting period, you will be immediately responsible for charges incurred today. We make every effort to obtain as much policy information prior to your appointment as possible. **In addition, we are not responsible for erroneous information, status, or coverage quoted to us by your insurance company. As stated by your insurance company, the information given to us is an ESTIMATE ONLY (NOT A GUARANTEE).**
4. Please Note.... Effective April 1st, 2019. A fee of $25 will be charged to the patient for cancellations or broken appointments less than 24 hours in advance. Signature _____
5. **Please be aware of the IMPORTANCE of confirming your dental appointments. We require all scheduled appointments to be confirmed via text or phone call at least a day before your scheduled appointment.**
   **** If you miss 3 or more appointments you may be dismissed from the clinic This is my signature stating I understand the dismissal policy._____**
   ** Patient dismissal is at the discretion of your dental provider.
6. To provide a complete evaluation of your teeth, additional x-rays may be required. Depending on the situation and insurance provider, some of the films may be partially covered or not at all. In the event they are not covered, they will be your financial responsibility.
7. My signature, or that of my representative or witness, indicates that I do understand the above, give my consent for dental treatment.

Patient Name: _____ Date: _____

Signature of Patient: _____ Date: _____

Signature of Legal Representative (If patient is under age 18): _____ Date: _____

(HIPAA- Healthcare Insurance Portability and Accountability Act)
"You May Refuse To Sign This Acknowledgement"

By my signature, I acknowledge that I have been offered a copy of Choice One Dental Care of Cartersville's Notice of Privacy Practices (HIPAA).

Patient Name: _____ Date: _____

Signature of Patient: _____ Date: _____

Signature of Legal Representative (If patient is under age 18): _____ Date: _____