Picayune Smiles

Dr. Joseph Daho
100 Haydon Oaks Dr.
Picayune, MS 39466
601-798-1135

DENTAL TREATMENT CONSENT FORM

Dear Patient,
Providing the highest quality dental care involves keeping you informed so you can make good decisions about your dental health. Please read the following information carefully. It describes the treatment that is planned for you and any risks and possible complications involved. You have a right to ask questions about anything that you do not understand. We will be pleased to answer your questions.

In general terms, your treatment or procedure(s) will include the following checked/highlighted items:

- Radiographs (x-rays) of the teeth and jaw
- Cleaning of the teeth
- Application of topical fluoride
- Application of plastic "sealants" to the grooves of the teeth
- Use of anesthesia to numb the teeth and tissues
- Treatment of diseased or injured teeth with dental restorations (fillings)
- Replacement of missing teeth with dental prostheses
- Removal (extraction) of one or more teeth
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of crooked teeth and/or oral developmental or growth abnormalities
- Use of sedative drugs to ease apprehensiveness
- Use of general anesthesia to accomplish the necessary treatment

Other:

____

RISKS INVOLVED IN SURGERIES may include:

- Soreness, swelling, bruising, and restricted mouth opening during healing, sometimes related to muscle stiffness and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
- Bleeding, usually controllable, but may be prolonged and require additional care.
- Drug reactions or allergies.
- Infection; possibly requiring additional care.

RISKS INVOLVED IN TOOTH EXTRACTIONS may include:

- Dry socket causing discomfort for a few days after extraction; requires further care.

- Damage to adjacent teeth or fillings.
- Sharp ridges or bone splinters; may require additional surgery to smooth the area.
- Portions of tooth remaining—sometimes fine root tips break off and may be deliberately left in place to avoid doing damage to nearby vital structures such as nerves or the sinus.
- Numbness; due to the proximity of the roots to the nerve (especially wisdom teeth). It is possible to injure the nerve during the removal of the tooth. The lip, chin, gums, or tongue could thus feel numb (resembling local anesthetic injection). This could remain for days, weeks, or very rarely, permanently.
- Sinus involvement; due to the closeness of the roots of upper back teeth to the sinus, or from a root tip being displaced into the sinus. Possible sinus infection and/or sinus opening may result, which may require medication and/or later surgery to correct.

RISKS INVOLVED IN ANESTHESIA may include:
Certain possible risks exist that, although rare, could include pain, swelling, bruising, infection, nerve damage and unexpected allergic reactions which could result in heart attack, stroke, brain damage and/or death.

Notes:____

I hereby authorize and direct Dr. Daho, assisted by other dentists and/or dental auxiliaries of his choice, to perform upon myself or my child (or legal ward for whom I am empowered to consent) the checked dental treatment(s) or oral surgery procedure(s). I certify that I have read and understand this consent form, that I have been given an opportunity to ask questions, and that all questions about the procedures have been answered in a satisfactory manner. No guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I understand further that I have the right to be provided with answers to questions that may arise during the course of my treatment or that of my child. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it.

I have been advised that medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, thus I have been advised not to operate any vehicle or hazardous device for at least 24 hours or until further recovered from the effect of the anesthetic, medications and drugs that may have been given me for my care. I agree not to drive myself home and to have a responsible adult accompany me until I am recovered from my medications.

Picayune*Smiles*

Joseph Daho, D.D.S.
100 Haydon Oaks Drive
Picayune, MS 39466
Phone: (601) 798-1135
Fax: (601) 798-6359

Office Policies, Financial Agreement, and Consent

Welcome and thank you for choosing Picayune Smiles for your dental care. Your clear understanding of our **Patient Financial Policy** is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies, and/or your responsibilities.

Insurance

When making an appointment with your dentist or hygienist, it is **your responsibility** to bring your DENTAL insurance card (or other proof of dental insurance). You also must confirm in advance with your insurance company that your coverage is effective. If you do not have proof of insurance at the time of your appointment, you will need to reschedule your appointment, or choose to be seen **without the insurance benefits and pay for your visit in full**.

You are responsible for knowing your insurance benefit coverage. We do not have access to the details of your individual policy. We will gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. If the insurance company does **NOT** pay within this time, **you will be responsible** for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, co-inurance, alternate benefits, or pre-existing conditions. You are responsible for all deductibles and the FULL patient portion **at the time of service**. Our office does not offer monthly payment plans. If there is an outstanding balance, we will send you an invoice that will require your full and final payment.

Check-In

Please bring your current insurance card with you to **EACH** visit. Without the insurance card, we will be unable to file your insurance, and **you will be responsible** for all charges for that visit. On follow-up visits, you will be asked to verify your personal information and update your medical history so that our records remain current.

Check Out

Please be prepared to pay for the current visit as well as any past balances on your account. Payments for any non-insurance fees is required at the time of service. Beginning **January 1, 2015**, we will not perform any additional services until all balances are paid in full. For your convenience, we accept cash, check, and most major credit cards.

Non-Covered Services

You are responsible for paying for any non-covered services. Our insurance estimate does not guarantee that your insurance company will pay for any services. It is an estimate only and you are responsible for any amounts that your insurance company does not pay within 45 days. Some services (doctor exams, x-rays, fluoride, and other procedures) are limited in coverage based on frequency and the amount of time since your last similar service. In dentistry, there are

many procedures that are considered by insurers as **non-covered** because they are elective or cosmetic. If you are coming in for a non-covered service, please be prepared to pay for the service **in full**. WE DO NOT KEEP TRACK OF YOUR INDIVIDUAL POLICY DETAILS--THAT IS YOUR RESPONSIBILITY. We will try our best to help provide you with information or answer your questions.

Return Check Fees

Any returned check from the bank for non-payment shall result in the patient's or Guarantor's account being assessed a **$25.00 fee per check**.

Late Payment Fees, Appointment Cancellations, and Finance Charges

Statements are mailed on the 15th of every month, or as soon as your insurance claim is closed. Your remaining balance is due **IN FULL** immediately. Your payment is considered late if the balance is not paid by the 1st day of the month following the statement date. **We now charge a minimum late payment fee of $5 and a maximum finance charge of 4% of your outstanding balance**. We will be happy to discuss waiving these charges for you when your balance is paid in full.

Failure to show up for a scheduled appointment, or cancellations on the day of your appointment are not allowed. Please give us 24 hours advance notice if you are unable to make it to a scheduled appointment. Any patient with more than one "day of appointment" cancellation or "no-show", will be required to pay in advance for their next appointment.

You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice. Signing below signifies that you have had the opportunity to view the privacy notice by requesting a copy or reading a copy located in the waiting room and you agree to the privacy policy of our office.

By signing below, I acknowledge that I have read, understand and agree to the Picayune Smiles Financial Policy, Dental Treatment Consent, and our Notice of Privacy Practices.

By signing below, I also acknowledge that I have been completely informed of all dental treatments and procedures in advance. I have had the opportunity to ask questions and understand that there are risks and complications to all dental procedures. I have read and signed the Dental Treatment Consent form provided to me by Dr. Joseph Daho. No guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction.

Effective date of notice: October 5, 2011

NOTICE OF PRIVACY PRACTICES

Picayune Smiles, LLC
Dr. Joseph Daho, DDS
100 Haydon Oaks Drive, Picayune, MS 39466
(601) 798-1135

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to

the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.