Consent Form for KRS 313.040

KRS 313.040 allows a Licensed Dental Hygienist to treat patient without the doctor being present in the office if the doctor has examined the patient within the last 7 months.

The statute requires a signed consent form for a patient to be seen under general supervision.

_____ I agree to be seen without the doctor being present in the office.

_____ I do not agree to being seen without the doctor being present.

Signature: _____ Date: _____

Consent for Dental Photography

I, _____ , authorize
Name

Alencar Family Dentistry to take photographs and / or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs and/or videos to be used for:

- Dental Records
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals and books
- Marketing materials including websites, social medias, printed materials and patient education

I understand that if the photographs and/or videos are used, my name and other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs and/or videos.

____ Check here if you do not want any photos and /or videos taken and used for any of the above purposes

_____ _____
Signature Date

Health Questionnaire cuestionario de salud

First, last/ primero, último _____ month-mes/Day-día/year-año

Patients Name/ nombre del paciente *Date of Birth/* fecha de nacimiento

Why are you seeking dental treatment currently? Por qué estás buscando tratamiento dental actualmente _____

_____

Emergency contact/ contacto de emergencia *Relationship to patient/*Relación con el paciente *Phone #/* Número de teléfono

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General Questions- this questionnaire will be used to help treat you safely. Please answer all questions as accurately as possible. *If NO, please check that box*. **Do not leave blank.**

este cuestionario se usará para ayudar a tratarlo de manera segura. Por favor, responda todas las preguntas con la mayor precisión posible. Si NO, marque esa casilla. No dejes en blanco.

Do you have any of the following? / ¿Tienes alguno de los siguientes?

	Yes/sí	No		Yes/sí	No
High Blood Pressure/ *Alta presion sanguinea*			**Anemia**		
Heart Murmur/*Soplo cardíaco*			**Bleeding disorder/** *desorden sangrante*		
Rheumatic Fever/ *Fiebre reumática*			**Kidney Disease/** *enfermedad del riñon*		
Mitral Valve Prolapse/*Prolapso de la válvula mitral*			**Renal dialysis/** *Diálisis renal*		
Angina pectoris/ Chest pain *Angina de pecho / dolor en el pecho*			**Organ transplant/** *Trasplante de organo*		
Heart Attack/ *Ataque al corazón*			**Cancer/** Type *tipo*:		
Prosthetic (artificial) heart valve *Válvula cardíaca protésica (artificial)*			**Radiation Therapy/** *Terapia de radiación*		
Irregular heart beat/*Latido del corazón irregular*			**Chemotherapy/** *quimioterapia*		
Pacemaker/ implanted defibrillator *Marcapasos / desfibrilador implantado*			**Epilepsy/ Seizures,** *convulsiones*		
Heart disease/ *Enfermedad del corazón*			**Stomach Ulcers/** *Úlceras estomacales*		
Heart or bypass surgery /*Cirugía cardíaca o de bypass*			**Colitis/ intestinal problems** *Colitis / problemas intestinales*		
Stroke/ *Carrera*			**Arthritis/** *Artritis*		
Emphysema/ *Enfisema*			**Artificial Joints/** *Articulaciones Artificiales*		
Asthma/ *Asma*			**Sexually transmitted disease/** Enfermedades de transmisión sexual		
Diabetes			**HIV/ AIDS…** *VIH / SIDA*		
Thyroid Disease/ *Enfermedad de tiroides*			**Tuberculosis (TB)**		
Hepatitis/ Type/*Tipo*:			**Psychiatric Treatment/**Tratamiento psiquiatrico		
Jaundice/ *Ictericia*			**TMD/ TMJ *(diagnosed/*** diagnosticado*)*		
Liver Disease/ *Enfermedad del higado*			**Sleep Apnea/***Apnea del sueño(diagnosed/* diagnosticado*)*		
Other/ otros: Please specify /especificar					

***This box* FOR WOMAN ONLY :**

Do you believe you are pregnant at this time? If so, how many weeks?

Please List any conditions not mentioned above, *Por favor enumere cualquier condición no mencionada anteriormente* **:** *(If none, write none)* (Si no hay ninguno, escriba ninguno)

_____

Medications: Please list all medications that you are presently taking, including herbal medications or nutritional supplements. *(If none, write none)* *Enumere todos los medicamentos que está tomando actualmente, incluidos los medicamentos herbales y los suplementos nutricionales. (Si no, escribe ninguno)*

_____

_____

__

Please list all major surgeries or hospitalizations: Haga una lista de todas las cirugías u hospitalizaciones más importantes:

_____

_____

Please list any allergies or reactions to medications: *(If none, write none)* *Por favor indique cualquier alergia o reacción a los medicamentos: (Si no tiene ninguno, escriba ninguno)*_____

_____

Do you smoke? ¿Fumas? _____

If so, How much and how long have you smoked? *Si es así, ¿cuánto y cuánto tiempo has fumado?* _____ _____

Do you use alcohol? *¿Usas alcohol?* _____

If so, How many drinks per week? *Si es así, ¿cuántas bebidas por semana?*_____

Do you use recreational drugs? *¿Usas drogas recreativas?* _____

If so, What type(s)? *Si es así,¿qué tipo(s)?*_____

Last recreational drug use? *¿Último uso recreativo de drogas?* _____

To the best of my knowledge, all above answers are true and correct. If I have any changes I will inform the dentist or hygienist at my next appointment. *Según mi leal saber y entender, todas las respuestas anteriores son verdaderas y correctas. Si tengo algún cambio, informaré al dentista o al higienista en mi próxima cita.*

Prescription Monitoring Program

_____my initials here *and* signature below acknowledge I have been informed, Dr. Jayme Oliveira is required by law to report to the Prescription Monitoring Program anytime prescriptions for narcotics or any controlled substances are prescribed. If I choose to refuse this, I am aware that Dr. Oliveira ***cannot*** prescribe any narcotics or controlled substance for me at anytime without further consent for this information to be reported.

_____ *mis iniciales aquí y mi firma a continuación reconocen que he sido informado, la ley exige que el Dr. Jayme Oliveira se presente al Programa de Monitoreo de Prescripciones en cualquier momento que se prescriban recetas para narcóticos o cualquier sustancia controlada. Si decido rechazar esto, soy consciente de que el Dr. Oliveira no puede recetarme ningún estupefaciente o sustancia controlada en ningún momento sin otro consentimiento para que se informe esta información.*

Patient Signature/*Firma del paciente***:** _____ Date/*fecha*: _____

Welcome Patient Information

Name: _____Preferred Name: _____
FIRST Name: Middle Initial Last name

Gender: circle one	**STATUS:** circle one	**Date of Birth**:	**AGE:**
MALE or FEMALE	MARRIED SINGLE MINOR		

Address: _____
Street City State Zip

SS# _____ Drivers License state and # (if applicable) _____ / _____
State ID #

List phone #'s in order in which to contact you. Cell #_____Home # _____

Email_____@_____.com

Patient employer (if applicable) _____

Full time college student, school name and city: _____

How did you hear about our office/ whom may we thank? _____

DENTAL INSURANCE INFORMATION
Primary Insurance Policy Name: _____
Subscribers Name: _____ Subscribers DOB: _____
Subscribers Social Security #_____Relationship to patient (circle one)**:** self / spouse/ parent/ other

Secondary Insurance** *(we do not accept assignment of benefits) we will however bill on your behalf but you will be responsible for payment, your insurance will pay claim to you.)*
Policy Name: _____
Secondary Subscribers Name: _____ DOB: _____
Subscribers Social Security #_____Relationship to patient (circle one)**:** self / spouse/ parent/ other

Person to contact in case of emergency (outside of immediate family household)

NAME: _____ Relationship: _____

Home Phone # _____Cell # _____ Work # _____

Address: _____ City/State/Zip _____

I hereby authorize payment directly to Dr. Jayme Oliveira Filho of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment regardless of my dental insurance coverage. I hereby authorize the dental office to administer such medications and perform such diagnosis; photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payer and/or other health professionals. I authorize this practice and those acting on behalf of Dr. Oliveira Filho to contact me on the numbers and emails listed for reminders and updates regarding my dental care or upcoming appointments.

Signature (or guardian if minor): _____ Date: _____

CONSENT FOR USE, DISCLOSURE OF HEALTH INFORMATION, NOTICE OF PRIVACY

Section A: Patient Giving Consent:

Printed Name: _____

Section B: To the Patient- Privacy Practices Notification and Consent. Please read the following statement carefully.

Purpose of consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. Without your consent to disclose we cannot send neither claims on your behalf to dental/medical insurance companies nor can we refer you to a dental specialist in the event one is needed.

Notice of Privacy concerns: You have the right to read our Notice of Privacy practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make o your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully before signing this consent.

We reserve the right to change our policy practices as described in our Notice of Privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy practice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation, submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and notice of privacy practices. I understand that, by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I am aware that a copy of Notice of Privacy Practices is available to me if I should so request it.

_____ Initial

Section C: Disclosure

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

By checking these boxes, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

✓ Call, text, Email and/or mail. This consent will be used to remind you of appointments billing, change appointments, insurance information, or any other professional contact needed.

(READ CAREFULLY) By placing my initials in this box I am **withdrawing consent** for this practice to contact me via email/text/phone calls. I am aware that placing my initials in this box requires me to contact this practice to schedule my appointments, check balances due and remember appointments scheduled. _____

(this will not prevent this practice from billing you for balances due, from service provided)

I allow you to give my clinical information to or answer questions from (*check all that applies)*:

☐ Spouse Name: _____ ☐ Full disclosure ☐ Appointment date & time only

☐ Parent Name: _____ ☐ Full disclosure ☐ Appointment date & time only

☐ Other: _____ ☐ Full disclosure ☐ Appointment date & time only
(Specify name and relationship)

☐ Restrictions of release noted: _____

By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. Your consent to disclose will permit us to send claims on your behalf to dental/medical insurance companies as well as referrals to a dental specialist in the event one is needed. If there are any restrictions they have been noted above.

Signature: _____ Date: _____

INSURANCE BENEFITS

Insurance Disclaimer (Please read carefully) Please note we do not accept nor participate with any DMO/HMO insurance plans, prepay plans, Medicaid or discount plans. Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted. Any treatment plan that our office proposes to you is an estimate of what your insurance coverage will be, it is not a guarantee. If you need exact payment of benefits, then a pretreatment is required. If you would like this done, you must specify to the office manager before any work is initiated.
(This takes 6-8 weeks). ____ (Initial)
Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your insurance plan does not pay within 120 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a credit to your account. Also remember dental insurance plans are not designed to cover all of your dental needs. I, _____, have chosen to allow Alencar Family Dentistry to file my insurance and accept full responsibility for this account and for all dentistry performed upon my family in this dental office. ***I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits***. I also understand that if my insurance company does not pay within 120 days of my date of service then I will become responsible to pay at that time.
Print Name: _____ Date: _____
Patient Signature: _____ Staff Signature: _____

Materials Used

This is to inform you that our office strives to use only the best, most appropriate up-to-date materials for restorations. Because of this, we no longer use amalgam (silver fillings) in our practice and use only composite (tooth colored) materials, porcelain and or gold.

Unfortunately, some insurance companies have not caught up to current standards. They may only pay for what they would have paid for an amalgam. Therefore you would be responsible for any remaining balance. Please check with your insurance as to your particular coverage. If you have any questions or concerns we would be happy to discuss this with you.

Please sign below to acknowledge that you have read and understand the above.

Printed name of patient: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Jayme Oliveira Filho

Financial Policy

Thank you for choosing us as your dental healthcare professional. Dental treatment is an excellent investment in an individual's health and wellbeing and we are committed to your treatment being successful.
Financial considerations should not be an obstacle to obtaining this important health service. Please understand that
payment of your bill is considered part of your dental treatment and payment is expected **in full** at the time services are rendered. The following is a statement of our financial policy which we require you to read, agree to and sign prior to any treatment. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we provide the following payment options:

- Cash, Check, MasterCard, Visa, and Discover
  - We offer a 5 % discount when fees in excess of $200 are paid in full by cash or check on or before the date of treatment and insurance is **not** utilized.

- Extended Payment Plan - based on approval through **CareCredit**
  - No initial payment
  - Payment plans ranging from 3-48 months. Some with no interest!
  - Fast, confidential service by phone, 1-800-365-8295, or online at their secure website, **www.carecredit.com.**

Regarding Accounts & Insurance
Your insurance coverage is a contract between you and your insurance company. Our financial agreement is between you and this office. It is therefore, your responsibility to know the benefits and limitations of your policy! We will however, assist you any way we can. Please be aware that any **estimated** co- payments/patient portions are due at time of service. The remaining estimated insurance balance will be due within 30 days whether the insurance company accepts or denies the claim. Payment is due within 10 days of receiving a statement unless previous arrangements have been made with our financial coordinator. Unpaid accounts will be turned over to collections. Furthermore, you agree to pay our $45 collections charge for any NSF checks as well as any collection/attorney fees that may be imposed by the collection agency. Any remaining balance that is not paid within 30 days of receipt of statement will be charged an interest rate of 18% annually and/or 1 .5% monthly.

Appointments

We have multiple communication tools available to us to help you remember your appointment you scheduled with the providers in this practice. This time slot is held for your care therefore It is important that you confirm your appointment with this office in a timely manner. After multiple attempt, if you do not confirm your appointment, we will remove your appointment from the schedule, causing you to have to reschedule to another time.
Once an appointment is made; please remember, that we have reserved this time just for you and your specific needs. We understand that on rare occasions true emergencies do arise such as illness and we try to be understanding of this. However, a charge will be applied to your accounts if failure to show or cancel/ reschedule an appointment without at least **48 of our business hours notice**. This charge will be calculated **at $30 per each 1/2 hour** that the appointment was scheduled for. Be advised that this fee covers only a portion of the overhead expenses such as utilities, supplies and employee salaries.

By signing below I have read, understand and agree to the above policies

Patient/Responsible Party:_____ Date: _____

If you have any questions, please ask your doctor BEFORE signing.

You have the right to be informed about your diagnosis and planned procedure so that you can decide whether to have a procedure or not after knowing the risks, benefits and alternative options. Your diagnosis and plan will be assessed, discussed and documented after your most recent examination. You will be given both a treatment plan and cost estimate for your recommended treatment.
I understand that good oral hygiene is essential to prevent decay and to assist in the successful treatment of dental conditions.

Drugs and Medications:
I understand that antibiotics, pain medications, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have told the doctor of any known allergies. I know it is important to take any medicines that are prescribed for me as directed to help minimize potential problems. Certain medications may cause drowsiness and I should not drive or operate hazardous equipment when using such drugs. If I have a problem, I should get appropriate medical care from either my doctor or in emergencies by calling 911.

Fillings:
I understand that a more extensive restoration than originally planned *may* be required due to additional conditions discovered during preparation. I also understand that my tooth *may not* be salvageable, and I *may* need other treatment options including a root canal or extraction. I understand that major changes in response to temperature *may* occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement. I understand every case is different and the dentist will discuss my options during my visit.

Crowns and Bridges:
I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need re-cementing. I will notify my doctor if that happens so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes in the color, shape, size, etc. of a crown I may want must be made prior to final fabrication of the restoration. It is my responsibility to return for tooth preparation and final cementation of the restoration as directed by my doctor. If the crown or bridge becomes dislodged at any time, I need to call the doctor. I understand I may need further treatment by a specialist if complications arise during treatment, and I am responsible for paying any of those costs.

Dentures:
I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent." Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustment and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less desirable result. A natural process of resorption of the bone occurs making it necessary to have an annual checkup. If unsatisfactory stabilization of the dentures occurs, other options including dental implants may be needed to assist in stabilization. If it is necessary to remake the denture because I did not return in the time needed, there may be additional costs.

Changes in Treatment Plan:
I understand that it may be necessary during treatment to change or add procedures because of conditions discovered during treatment that were not evident during examination. If so, I will be advised by my doctor.

I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understand the above and give my consent to have the recommended treatment. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Printed Name: _____ Date of Birth: _____

_____

Patient's (or Legal Guardian's) Signature Today's Date