HARBOR COUNTRY DENTAL
HILLARY V. KNIGHT, DDS

105 W. Merchant Street
New Buffalo, MI 49117
P: 269-469-3140
F: 269-469-6182
team@harborcountrydental.com
www.harborcountrydental.com

Patient Name _____
Date of Birth _____

CONSENT FOR TREATMENT: By signing this form, the patient consents to receive dental treatment by the providers at Harbor Country Dental.

Common risks associated with dental treatment include:

1. Short term sensitivity or discomfort after the procedure
2. Stretching the corners of the mouth with cracking and bruising
3. Swelling/bruising or bleeding gums
4. Limited mouth opening for several days or weeks in patients with history of TMD
5. Complication with local anesthesia, including injury to the nerve underlying the teeth causing numbness or tingling of the lower lip and tongue that may persist for several weeks, months or in rare instances, permanently
6. Allergic reaction to anesthetic or other medications

The patient or guardian must agree to discuss medical history with the dentist and dental team, including any serious medical problems or injuries, heart problems and drug allergies, in an effort to mitigate any complications of treatment.

There exists a risk of failure, relapse, selective re-treatment, or worsening of the dental condition despite the care provided. No one can guarantee the success of recommended treatment. However, it is the dentist's opinion that recommended treatment would be helpful and that a worsening of disease conditions may occur without the recommended treatment.

Lastly, there may be situations where another doctor may need to be consulted prior to treatment or the patient may need to be referred to another dental provider. Original records, including radiographs, are the property of Harbor Country Dental. (You may also request a copy of your records and x-rays in writing to team@harborcountrydental.com.)

__ I consent to dental treatment, understanding the risks of dental treatment, and agree to share medical information with the dental team.

__ I consent to the release of my information, advice and treatment to another doctor should my dental needs require doing so.

_____ _____
Printed Name of Patient/Parent/Legal Guardian Relationship to Patient

_____ _____
Patient/Parent/Legal Guardian Signature Date

Patient Consent & Authorization for Release of Protected Health Information

Please Print

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____ Telephone Number: _____

E-mail Address: _____

Patient Authorization

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

_____

_____

I hereby authorize _____
Name of individual(s) and/or organization providing information

to release the above-described information to _____.
Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

_____.

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on _____. If I do not
Expiration date or event
specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

Received by: _____ Date: ___/___/___

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FINANCIAL AGREEMENT: **Harbor Country Dental is a fee-for-service dental practice, which means full payments for dental services rendered will need to be arranged with our office prior to or on the date of service.** This model allows us to provide the very best care to our patients as new care is evolving, rather than providing care within the constricted range of benefits a particular dental "insurance" company will allow under their plan. The treatment recommended by our office is always based on your individual needs, not on what a particular insurance company will cover.

DENTAL INSURANCE: As a courtesy to our patients utilizing out-of-network dental insurance benefits, our team will process dental insurance claims within 72 hours of treatment, and reimbursements will go directly to the plan subscriber. **It is your responsibility to provide and update your insurance information. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is also entirely your responsibility.** We encourage our patients to call their insurance companies for estimates on benefit coverage, and we will provide dental codes for you to use in discussing coverage with your insurance company. Please understand that we simply cannot know what your individual dental policy will cover, but that we are happy to help you get the information you need. Alternatively, our office can request a pre-authorization of insurance benefits upon your request. Benefit estimates are usually returned within 6 weeks. Please take the time to review your insurance contract thoroughly so we may best serve you. With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your dental needs.

IN-HOUSE MEMBERSHIP: Patients not utilizing traditional dental insurance qualify for **our in-house Kleer membership plan. It's a simple, affordable, 12 month subscription that includes your routine dental care and discounts off other treatment.** It's a great option for patients that are looking for an affordable way to commit to great oral health. Find more details on: www.harborcountrydental.com.

MINOR PATIENTS: The legal guardian of the minor is responsible for full payment on the day of service. In the case of divorced or separated parents, the legal guardian accompanying the child is responsible for payment and will collect any portions due from secondary parties.

BROKEN APPOINTMENTS: Our practice requires 48 weekday hours notice to reschedule, or a $75 fee may be charged.

If you have financial concerns, please discuss payment arrangements with our office ***prior to*** treatment. There will be a charge of 10% APR on all accounts over 30 days past due, and all accounts over 90 days will be sent to a collection agency for further action, which may result in legal action and have a negative effect on your credit score. Additionally, you are responsible for any fees associated with payments on your account, which includes: a $35.00 fee for each returned check or fee incurred for any credit card chargebacks.

__ I have read and fully understand all policies listed above. This consent shall be considered in effect until revoked.
__ I authorize Harbor Country Dental to process credit card transactions initiated by me via mail, online, or phone, and I authorize my credit institution to pay.
__ I understand that in the event my account becomes delinquent, I will be responsible for any collections, legal fees, and any other charges incurred to collect this account.

_____ _____
Printed Name of Person Completing Form Relation to Patient

_____ _____
Signature of Person Completing Form Date