CD Virginia Dental, P.C., dba

KONIKOFF FAMILY DENTISTRY

220 W. Brambleton Avenue, Ste. 110
Norfolk, VA 23510

7400 Granby Street, Ste. D
Norfolk, VA 23505

931 Chesapeake Road
Chesapeake, VA 23325

GENERAL CONSENT AGREEMENT

CONSENT TO TREATMENT

I consent to receive dental services, including examination, dental prophylaxis (cleaning) and routine fillings from **Konikoff Family Dentistry** (the "PRACTICE"). I understand that the initial visit may require radiographs to complete the examination, diagnosis and treatment plan. I understand I will be provided a treatment plan for necessary services; however, I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to my treating dentist to make any/all changes and additions as necessary. I further understand that clicking, popping, and pain in the jaw joint may occur as a normal part of treatment; however, should the discomfort become intolerable, I may be referred to a specialist for treatment, the cost of which is my responsibility.

TREATMENT OUTCOMES

I understand that the practice and my treating dentist cannot guarantee treatment outcomes. I am responsible for reviewing the treatment plan and asking any questions I may have prior to receiving treatment. I have the right to accept or reject treatment recommended by my treating dentist. By consenting to my dentist's treatment plans, I acknowledge that I accept known risks and complications of such treatments. It is my responsibility to fully inform the dentist of my medical history, all medications or other drugs that I am using and otherwise truthfully answer all questions related to my care. It is also my responsibility to follow my dentist's pre- and post-treatment instructions and oral care instructions. I acknowledge that failure to comply with these requirements may increase the chance of poor treatment outcomes.

CONSENT TO RECEIVE COMMUNICATION

I agree that, when I provide my landline or cell phone number(s), I am giving you express consent to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages to voicemail or text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of the practice. I will be responsible for all data and other charges for text or email messages. Providing a telephone or cell number or email address is not a condition of receiving services. This consent to receive voicemails, emails and text messages applies to future communications unless I request a change in writing, by clicking an unsubscribe link provided in emails, or by replying STOP to all text communications.

I further acknowledge that these communications may contain information that is protected under state and federal privacy laws, and that my consent means that THE PRACTICE may use the methods I identify below to contact me about appointments, my dental treatment, payments and other information that may contain protected health information. THE PRACTICE will use all reasonable efforts to minimize the amount of protected health information disclosed and otherwise protect my personal data; however, I am aware that such communications will not be encrypted and that there may be some risk that such messages may be read or accessed by a third party. By signing below my acceptance to receive communications via text, email or voicemail, I am agreeing that I have been informed of this risk and that I still prefer to receive communications in these manners.

PLEASE INITIAL

_____ I APPROVE _____ I DECLINE _____ I REVOKE - Authorization to receive communication via *TEXT.*

_____ I APPROVE _____ I DECLINE _____ I REVOKE - Authorization to receive communication via *EMAIL.*

_____ I APPROVE _____ I DECLINE _____ I REVOKE - Authorization to receive communication via *VOICEMAIL.*

CONSENT TO PHOTOGRAPH

I understand photographs, videotapes, digital and/or other images may be made/recorded for identification, treatment and payment purposes. These will be part of my record and will not be used for any marketing or other purposes. I will specifically authorize in writing any other use or disclosure of any image or recording.

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CONSENT TO ELECTRONIC PRESCRIBING

I authorize an electronic prescribing network to release my medication refill history to the practice for the purpose of continued treatment.

CONSENT TO SCHEDULING AND APPOINTMENTS

I understand that it is my responsibility to change or cancel appointments I can no longer keep at least 2 business days prior to the scheduled appointment. If I do not do so, the Practice may charge me a cancellation fee of up to $100 per scheduled hour. I further understand that multiple short notice cancellations may result in my dismissal as a patient.

PAYMENT FOR SERVICES

I understand that I am responsible for all charges for the care I receive. If I do not have dental insurance coverage, I will pay all amounts for which I am responsible in full, in advance of treatment. It is my responsibility to provide accurate and up-to-date information regarding my dental insurance coverage. I agree that payments from my dental plan may go directly to the practice. If I should receive the payments, I understand that I will be responsible for immediately paying such amounts to the practice. Depending on the type of coverage I have, my responsibilities are as follows:

***IN NETWORK*:** If my treating dentist is in-network with my dental insurance plan, I will be billed pursuant to the terms of my insurance policy and my dentist's contract with the insurer. Even when the practice and my treating dentist are a participating provider with my insurance, I understand that the practice may hold me responsible and collect all charges in any one of the following situations:

- When I choose to have a service that my dental plan covers but I do not obtain the required referral or prior authorization from my health plan.
- When I choose not to use my dental plan and agree to pay for services myself.
- When I receive services that are not covered under my dental plan

OUT OF NETWORK: If my treating dentist is not a participating provider with my insurance, I will be required to pay for all treatment in full, in advance. The practice may file for insurance coverage as a courtesy and apply anything they pay towards my account. If payment from my insurance company results in an overpayment on the account, I will be reimbursed by the practice.

ALL PAYORS: Regardless of whether my treating dentist is participating provider, I will be responsible for any deductibles, co-payments, the costs of uncovered services and any other part of the bill that my dental plan says I must pay. If for any reason I do not pay, in full, the amounts I owe the practice, I will also reimburse the practice for all costs of collection, including legal fees and a 25% collection fee of the total amount submitted to the collection agency. I also agree the practice may charge me interest equal to 2% monthly on all balances that have been outstanding for thirty (30) days or more.

RELEASE OF INSURANCE BENEFITS

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentists or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to CORDENTAL Group's use and disclosure of my protected health information to carry out payment activities in connection with insurance claims. I hereby authorize and direct payment of the insurance benefits otherwise payable to me, directly to CORDENTAL Group and its partnered affiliates.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ THIS CONSENT AGREEMENT AND AGREE TO THE STATED ITEMS AS THEY HAVE BEEN OUTLINED. I HAVE BEEN GIVEN THE OPPORTUNITY TO HAVE MY QUESTIONS ANSWERED AND UNDERSTAND THAT I MAY MAKE INQUIRY TO THIS AGREEMENT AT ANY TIME. I FURTHER ACKNOWLEDGE THAT I MAY REVOKE MY CONSENT TO ALL OR ANY PART OF THIS CONSENT AGREEMENT AT ANY TIME BY DOING SO IN WRITING.

_____	_____
PATIENT NAME (PRINTED)	DATE
_____	_____
SIGNATURE OF PATIENT/LEGAL RESPRESENTATIVE	RELATIONSHIP TO PATIENT