CD Virginia Dental, P.C. dba **Konikoff Family Dentistry**

DENTAL CONSENT AGREEMENT

1) **CONSENT TO TREATMENT:** I consent to receive dental services, including examination, dental prophylaxis (cleaning) and routine fillings from **Konikoff Family Dentistry (KFD)** ("you" or 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.

2) **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.

3) **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:

   a. 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.
   b. When I choose not to use my dental plan and agree to pay for services myself.
   c. 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 a 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 collection agency fees. 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.

4) **CONSENT TO PHOTOGRAPH**: I understand photographs, videotapes, digital and/or other images may be made/recorded for identification, treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my image or recording.

5) **ELECTRONIC PRESCRIBING**: I authorize an electronic prescribing network to release my medication refill history to KFD for the purpose of continued treatment.

6) **RELEASE OF INFORMATION:** I authorize KFD practice site(s) to release healthcare information for purposes of treatment, payment, or dental care services. Dental care information from other encounter(s) at other KFD practice locations may be made available to subsequent KFD-affiliated sites to coordinate care. Dental care information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Dental care information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

7) **SCHEDULING AND APPOINTMENTS:** I understand that it is my responsibility to change or cancel appointments I can no longer make 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 $100 per scheduled hour.

8) **DISCLOSURES TO FAMILY AND FRIENDS:** I give permission for my health information, including billing and treatment records, to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			

I may revoke or modify this specific authorization in writing at any time. In addition, if anyone has the legal right to act on my behalf (such as the parent of a minor or court-appointed guardian), I understand that you may share health information with them regardless of whether I have identified them above.

9) **COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT**: I agree that, unless I expressly tell you otherwise, 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.

Unless I expressly decline to give consent below, I acknowledge I may be contacted via voicemail, text, or email. 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.

1. I decline_____I revoke_____ to receive communication via **text** (Initial please)
2. I decline_____ I revoke_____ to receive communication via **email.** (Initial please)
3. I decline_____ I revoke_____ to receive communication via **voicemail.** (Initial please)

10) **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received/reviewed KFD's Notice of Privacy Practices. I understand that I may contact the Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

I agree to the items as outlined in the Agreement.

Name (Print): _____

Signature:_____

Relationship to Patient (Self/Parent/Personal Representative): _____