Kathryn D. Jendrasik-Savitsky, DMD, PA

15825 Ballantyne Medical Place, Ste. 150, Charlotte, NC 28277

INFORMED CONSENT

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

Patient Home Phone: _____ Mobile/Work: _____

Name of Parent/Legal Guardian (if patient is a minor):_____

Parent/Legal Guardian Address and Phone (if different from patient):_____

_____

INFORMED CONSENT: I hereby authorize Dr. Savitsky, her staff and associates to render my dental care. I understand that I have the right to choose to NOT have work done as long as I know the risks of not having such work completed. I understand that there are inherent risks and possible side effects to all types of dental work, which include but are not limited to: reactions to the anesthesia (including permanent numbness, soreness at the injection site and allergic reactions, death), cuts and bruises as a result of the stretching of the lips, cuts or damage to the tissue and tongue, fillings requiring additional treatment (root canals and crowns, among other possibilities), and reactions to products used in our practice (latex, chemicals, and/or medicines). **THIS IS NOT A COMPLETE LIST OF POSSIBLE SIDE EFFECTS AND/OR RISKS ASSOCIATED WITH DENTAL TREATMENT**. Unforeseen conditions may be revealed that necessitate an extension of the original procedure or different procedure. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment or worsening of any condition despite the care provided. However, Dr. Savitsky has reasonably determined that the procedure is necessary and the potential benefits outweigh the risk of abandoning treatment. **BY SIGNING BELOW, I HEREBY CONSENT TO DENTAL TREATMENT AND THAT I UNDERSTAND THE RISKS ASSOCIATED WITH DENTAL TREATMENT.** I understand that Dr. Savitsky cannot and does not make guarantees or assurances regarding any treatment or care. I agree that I have made and will continue to make Dr. Savitsky aware of any allergies, medications, all prior surgeries, and conditions to which I (or my child) suffer.

Patient Signature: _____

For Parents/Legal Guardians: I hereby affirm that I have the legal authority to make medical and dental decisions on behalf of the patient stated on this form.

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____

Patient Name: _____

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HIPAA

State and federal law does not permit us to provide your dental information to anyone other than the patient except in limited circumstances relating to treatment, such as insurance companies and other healthcare professionals. If you would like your information shared with anyone else, please let us know the name(s) and relationship(s) of the person(s) with whom we are to share your information. If none, state "none."

Name of Person whom I give Dr. Savitsky and her staff permission to disclose my information:

_____ Relationship: _____

Patient Signature: _____

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Parent/Guardian Name (if patient is minor): _____

APPOINTMENTS

We value the time we have set aside to see and treat you. If you are not able to keep an appointment, we require a 24-hour business day notice. There is a charge of $40 for missed appointments or same day cancellations. If a patient misses (without proper notification) more than three visits, we have the right to terminate all services.

1. If you are late for your appointment (more than 15 minutes) we will do our best to accommodate you; however, on certain days it may be necessary to reschedule your appointment.
2. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
3. Before making an appointment, please check with your insurance company as to whether the visit will be a covered visit. **Initial_____**

INSURANCE

Please understand that:

1. It is your responsibility to keep us updated with your correct insurance. All patients must present an insurance card (if applicable) when checking in. **If the insurance company you designate is incorrect you will be responsible for payment of the visit and you will need to submit the charges until the correct insurance plan is billed for reimbursement.**
2. Some insurance companies require you to select from a list of specific offices. You will be financially responsible for the visit if the insurer does not pay.
3. It is your responsibility to understand your benefit plan with regard to covered services. It is also your responsibility to know if a written referral or preauthorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. **Initial_____**

FINANCIAL RESPONSIBILITY

1. According to your insurance plan, you are responsible for any and all copayments, deductibles, and co-insurances.
2. Co-payments and deductibles are due at the time of services.
3. Self-pay patients are expected to pay for services in full at the time of the visit.
4. Patients with an outstanding balance of more than 90 days overdue, who do not have a payment plan, must make arrangements for payment prior to scheduling appointments. **Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason.** Any balance outstanding longer than 90 days will be forwarded to a collection agency unless prior payment arrangements have been set up with our office. Date counts from the day the work was done.
5. We accept cash, checks, Visa, American Express and MasterCard credit and debit.

6. A $40 fee will be charged for any checks returned for insufficient funds. **Initial _____**

RECORDS

1. All requests for dental record release/transfer **MUST** be submitted in writing as per NC law and accepted healthcare guidelines. Please allow 3-business days for processing of such requests.
2. There may be a charge for a copy of your complete record. **Initial _____**

PRESCRIPTION REFILLS

1. For medication refills we require a **24-hour (i.e., 1 business day)** notice. Please plan accordingly. **Initial _____**

I have read, understand, and agree to comply with these office policies. I understand the risks associated with dental care and I consent to such treatment. I further accept the responsibility for any payment that becomes due as outlined.

Signature of Patient or Parent/Guardian: _____