Residential Dental Care

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CONSENT FOR DENTAL TREATMENT

Patient's Name:_____ Sex:_____

Patient's Home Address:_____

City, State, Zip:_____

Social Security Number:_____-_____-_____ Birth date:_____

Name of facility where you reside:_____

Facility Address:_____

City, State, Zip:_____

Facility Contact Name:_____ Title:_____ Phone:_____

Physician' Name: _____

Physician's Address:_____

City, State, Zip:_____

Physician's Phone:_____ Physician's Fax:_____

Name of Dentist:_____

Dentist's Address:_____

City, State, Zip:_____

Dentist's Phone:_____ Dentist's Fax:_____

The following services may be provided:

- Oral Cancer / Soft Tissue Examination
- Assessments of dental health
- Prophylaxis
- Fluoride Varnish
- Pit and Fissure Sealants
- Nutritional Counseling
- Oral Health Education
- Tobacco Cessation
- Denture Assessment and Cleaning

Consent for Dental Treatment

(continued)

Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the confidentiality of your health information. This describes how we may use and disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that we are permitted or required by law. We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example, your health/dental information may be provided to a dentist or physician to whom you have been referred to ensure that the dentist or doctor has the necessary information to diagnose or treat a condition. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your care. Sensitive patient information will be transported as a matter of necessity and course of business. As such a transportation protocol is important. Patient records will be transported in trunk of the vehicle. When going from the vehicle to the patient the records will remain in the hygienists backpack. We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

NAME OF RESPONSIBLE PARTY: _____

Phone Number: _____ Fax: _____

Mailing / Billing Address: _____

City, State, Zip: _____ Relationship to Patient: _____

By signing below, you are consenting to dental hygiene services provided by Residential Dental Care, and agree that you or your responsible party will be responsible for all payments. You understand that treatment may be obtained at the patient's dental home rather than a mobile dental facility and that obtaining duplicate services at a mobile dental facility may affect benefits that he or she receives from private insurance, a state or federal program, or other third-party provider of dental benefits. You also agree that Residential Dental Care may review your medical records, and that a photo may be taken of you for the files.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY Date

_____ _____

SIGNATURE OF POWER OF ATTORNEY FOR HEALTH CARE Date