MilleniuM Dental, LLC.

Informed Consent for Dental Treatments and Procedures

Please initial in front of each statement

____ You; the patient, have the right to accept or reject dental treatment recommended by your dentist.
Prior to consent to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

____ X-rays enable the provider to view dental cavities, abnormalities, development, and eruption of teeth. They are necessary for proper diagnosis and evaluation purposes. Alternative treatment: none; limited visual examination. Consequences of not performing: missed diagnosis. Common risk: Radiation exposure to soft and hard tissue.

____ Cleanings involve thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal of soft plaque build-up and harder calculus deposits above and below the gum line. Benefits of dental cleanings include: healthy oral environment; also reduction/elimination of bleeding, odor, and periodontal disease. Discontinued or interrupted treatment could result in further inflammation and infection of gum tissue; lead to more tooth decay , and deterioration of surrounding bone structure which could lead to tooth loss. Common risks involve bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint.

____ I understand that antibiotics, analgesics, and other medication can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

____ I understand that during treatment it may be necessary to change and 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 understand that changes will be discussed prior to treatment and I give permission to the dentist to propose any/all changes and additions as necessary. I understand that any changes may affect my copayment for services rendered.

____ I give permission to the dental office to bill my dental insurance provider for treatment provided, if applicable.

Patient/ Guardian signature:
X_____
Date:
X_____

MilleniuM Dental, LLC.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have read a copy of this office's Notice of Privacy Practice.

Patient/Guardian printed name:
X_____

Patient/ Guardian signature:
X_____

Date:
X_____

For Office Use Only

We attempted to obtain written acknowledgement of recipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

MilleniuM Dental, LLC.

Written Financial Policy

Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patient as possible by offering payment options.

- We require payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.
- We accept payment in thirds for treatment over $500.00. For plans requiring multiple appointments, alternative payment arrangements may be provided.
-For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment.
- A fee of $75.00 will be charged per hour to patients who cancel or miss two appointments without 24 hour notice.
- We charge the fee from the bank of $34 for returned checks.
- You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts.

Payment options :
- Cash/ Check/ Visa/ Mastercard/ American Express/ Discover
-6 months INTEREST* Payment Plans** from CareCredit allows you to pay over time with 6 month No Interest*

If you have any questions, please do not hesitate to ask. We are here to provide you with the dentistry you want and or need.

Patient, Parent or Guardian Signature:

x_____ Date:_____

Print Name:

x_____ Date:_____

*If paid with the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly Payment required.
**Subject to credit approval
However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.