GOOD NEWS DENTAL

Consent Form & Privacy Policy

Patient Name: ____ **DOB:** ___/___/_____ **Age:** ___

How did you hear about Good News Dental? ____

Please select each line for applicable/accepted items:

Initials

_____ **Fluoride Varnish treatment, if indicated.**

_____ **Sliding Fee discount (if income is less than 200% of FPL). Proof of income and "sliding fee scale" form will be required.**

_____ **OHP Insurance (ODS Community Dental): Group #:** ___________ **Member ID:** ___________

When it is time to schedule the next cleaning appointment, I would like a: ☐ call ☐ text

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 (HIPPA), 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 to whom you have been referred. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your care. 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 treatment.

By signing below:

I give consent for dental hygiene preventive/therapeutic treatment for the patient.
I reviewed the Privacy Practices above.
Permission is granted to Review of Medical Records by hygienists/dentists participating in care/treatment.
Permission is granted to send and receive patient health information (including, but not limited to: chart notes, images, videos, radiographs) via electronic means: e-mail, SMS, tele-dentistry. (patient to provider, provider to patient, and between providers).
Permission is granted to take pictures of patient for chart and/or patient and professional educational purposes, and images, videos, radiographs in assessment/data gathering procedures.
I understand that services provided are preventive only, and not comprehensive oral health care. Patients should be seen by a licensed dentist for comprehensive services, and "Good News Dental" is happy to assist in obtaining a referral for further dental planning and treatment. We recommend annual exams by a dentist.
If I don't have my teeth cleaned regularly (custom interval recommended by my hygienist), problems may arise. I understand that my dental treatment is important for my overall health.
Permission is granted for leaving a detailed message at the phone number and/or email provided below.
I understand I have the right to revoke this authorization, in writing, at any time.

Patient/Personal Rep Name: ______________________________ **Relationship to Patient:** _______________

Billing Address: ____

Contact Phone #: ____________________ **Text?: Y / N (circle)** **Email:** _________________________

Signature of Patient (Responsible Party)*: ______________________________ **Date:** _______________

***The Patient (or Responsible Party) agrees to be fully responsible for total payment for treatment accepted & performed. Does not apply to ODS Community Dental members.**