Donna L. Smolinski, D.M.D., P.A.
***Sensitive* Dentistry**
970 Kings Highway Blvd.
Port Charlotte, Florida 33980

Serial No: 57121

Patient:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Signing this document indicates that you have received a copy of this practice's Notice of Privacy Practices.

Signature: _____ Date: ___/___/___

*Note that you may refuse to sign this acknowledgement.

FOR OFFICE USE ONLY

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

☐ Individual refused to sign

☐ Communications barriers prohibited the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

_____

_____

Donna L. Smolinski, D.M.D., P.A.
***Sensitive* Dentistry**
970 Kings Highway Blvd.
Port Charlotte, Florida 33980
drsmolinski@teleoservices.com

Serial No: 57122

Patient:

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT CONSENT

NAME:_____
ADDRESS: _____
TELEPHONE: _____ E-MAIL_____
SOCIAL SECURITY #: _____-_____-_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment payment activites and healthcare operations , of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our notice. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Office Manager, who is our HIPAA contact person. Please understand that any revocation will not be affect any action taken prior to that time and that we may decline to treat you or to continue treating you if you revoke this Consent.

Be advised that your signature below indicates that you have had a full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. You understand that you are giving consent to use or disclose your protected health information for the outlined purposes.

SIGNATURE:_____
DATE:_____/_____/_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's
Name:_____

_____
Relationship to
Patient:_____

PRACTICE POLICIES

Serial No: 57123 **Patient:**

1) Before any treatment is rendered in this office, this form must be read completely, its contents thoroughly understood, and it must be signed. Your signature at the bottom of the form is your confirmation that you have done this.

2) Each patient is required to complete a "Patient Information" Questionnaire. This may be in the form of a document that you fill out or a series of questions which you are asked by one of our staff as they enter the information directly into the computer. This information is confidential and gives us facts pertinent to contacting you, payment items, insurance, and most important, necessary information about your health. Your signature below indicates that you have answered these questions to the best of your ability and that you understand that any errors or omissions made by you are not the responsibility of any one in this office. The outcome of your treatment and your health could be placed in jeopardy if we are not completely informed of all relevant facts.

3) Your signature below indicates that you will pay for services as they are rendered. In an effort to keep costs down and our fees reasonable, it is the normal practice of this office not to accept direct assignment of your insurance benefits. However, in an effort to assist you in submitting your claim, we can produce computer generated insurance forms which will enable you to be promptly reimbursed by your insurance carrier. We accept cash, check, Discover, MasterCard and Visa, American Express, Wells Fargo financing & Care Credit card for payment. We have also made arrangements through a finance company to get same day approval of a line of credit which will provide you with the ability to make smaller monthly payments to cover your dental care. **When using a credit or debit card, there will be 3.75% added to your total bill. We made this change as a result of Covid-19 and the challenging environment it has brought everyone. We did not want to raise our prices. For cash-paying- or check paying- customers, the price is the exact same. For credit, we are simply passing on the cost of card acceptance. We, as a business, do not make one penny off the higher credit price. Thank you for understanding.**

4) We want your visit to be enjoyable, with as little waiting as possible. Therefore, our patients are seen by appointment. Your scheduled time is set aside for you. Failure to keep a scheduled appointment or last minute cancellations prevent us from seeing patients and increases our costs. While we all experience unforeseen problems, repeated non-compliance with this policy will result in fees assessed to the patient. Please let us know as soon as you are aware that you will be late or cannot keep the appointment.

5) Please be advised that if a "coupon" or other advertised discount certificate or offering is to be utilized toward your treatment at any time, some restrictions do apply. The coupon or certificate is ONLY valid for the exact procedures indicated in the printed offering by ADA treatment code only and only in the exact combination of services or conditions as specified. No substitutions or alterations will be honored. Any and all dental services provided outside the parameters of the coupon or offering will be billed at the regular customary fee and payment in full is expected as services are rendered. Additionally, any duplicate radiographs or other records requested by the patient that were initially provided to the patient at a discounted rate originally, will require payment in full of the original customary fee to perform and provide that treatment prior to release of those duplicate radiographs &/or records to the patient to be utilized outside of this practice.

6) If the patient is a minor, your signature below certifies that you are the parent or legal guardian, or that you have medical power of attorney for this patient. You are further authorizing our staff to administer necessary treatment, including, but not limited to x-rays and the administration of anesthetics whether or not you are actually present when the treatment is rendered. If you are present at our office for the treatment, we request that you remain in our reception area during actual treatment. We have found that children cooperate much better without parents present in the room. We will keep you informed as treatment progresses. Exceptions to this policy are determined by the doctor on a case by case basis.

7) Your signature below also indicates that in the event it becomes necessary to turn your account over to a collection agency or attorney to rectify overdue delinquent balances, you will be responsible for payment of any fee incurred by this office in the process.

Print Patient Name	Print Parent or Guardian Name (If applicable)	Signature

POSSIBLE COMPLICATIONS OF ORAL BISPHOSPHONATE MEDICATIONS

Please read and sign the information below. If you have any questions, please ask your doctor BEFORE you sign.

Serial No: 57124 **Patient:**

Having been treated previously with oral Bisphosphonate drugs you should be aware that there is a very small, but real risk of future complications associated with dental treatment. This risk is currently estimated to be less than 1/10th of one percent. Bisphosphonate medications appear to adversely affect the health of jaw bones, thereby reducing or eliminating the jaw bones ordinarily excellent healing capacity. This risk is increased after surgery, especially extraction; implant placement or other "invasive" procedures that might cause even mild trauma to the bone. Spontaneous exposure of the jaw bone (osteonecrosis) may result. This is a smoldering, long term, destructive process in the jaw bone that is often very difficult or impossible to eliminate.

Your medical/dental history is VERY important. We must know the medications and drugs that you are currently taking as well as those medications you have taken or received in the past. An accurate medical history, including names of your physicians is important.

The decision to discontinue oral Bisphosphonate drug therapy before dental treatment should be made by you in consultation with your medical doctor.

If complication occurs, antibiotic therapy may be used to help control infection. For some patients, such therapy may cause allergic responses or have undesirable side effects such as gastric discomfort, diarrhea, colitis, etc. Despite all precautions, there may be delayed healing, osteonecrosis, loss of bone and soft tissues, pathologic fracture of the jaw, oral-cutaneous fistula (open draining wound), or other significant complications.

If osteonecrosis should occur, treatment may be prolonged and difficult, involving ongoing intensive therapy including hospitalization, long-term antibiotics, and debridement to remove non-vital bone. Reconstructive surgery may be required, including bone grafting, metal plates and screws and/or skin flaps and grafts.

Even if there are no immediate complications from the proposed dental treatment, the area is always subject to spontaneous breakdown and infection due to the condition of the bone. Even minimal trauma from a toothbrush, chewing hard food or denture sores may trigger a complication. Therefore, good consistent dental care is imperative.

Long-term postoperative monitoring may be required and cooperation in keeping scheduled appointments is important. Regular and frequent dental check-ups with your dentist are important to monitor and attempt to prevent breakdown in your oral health.

I have read the above information and understand the possible risks of undergoing any planned dental treatment as well as the risk and complications associated with delaying and/or avoiding the proposed treatment. I understand the importance of providing a complete and accurate health history. I attest that I have provided the most accurate and complete health history information possible. I realize that despite all precautions that may be taken to avoid complications; there can be no guarantee as to the result of the proposed treatment. I also certify that all of my questions have been answered to my fullest satisfaction regarding my proposed treatment and any possible complications related to my condition and performing this treatment as well as my condition and delaying or avoiding performing the proposed treatment.

Have you ever or are you now taking any variety of Bisphosphonate medications? ___ Y ___N

Patient Signature:_____ **Date:**_____

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