CHATTANOOGA PERIODONTICS
& DENTAL IMPLANTS

General Consent

The success of periodontal therapy and implant treatment is dependent on many factors including the severity of the periodontal destruction, the patient's general physical status, and the patient's ability and willingness to perform proper oral hygiene and to stay on a recall program after active treatment. Naturally, we will make every effort to keep you informed of your needed treatment. Your involvement and understanding are very important in the long-term success of your periodontal and implant therapy.

Periodontal and implant treatment involves complex procedures, and during the course of treatment unusual and unanticipated problems can arise. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic material deemed appropriate by the doctor. I authorize that such diagnostic material may be released to third party payors and/or other health professionals and can be used for professional education without identification. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using medication has certain risks including: redness, swelling, pain, itching, vomiting, dizziness, drowsiness, miscarriage, cardiac arrest, and/or lack of coordination. During periodontal and implant treatment, possible complications can arise including bleeding, prolonged numbness, and sensitive and/or loose teeth. I understand that I can ask for a complete listing of any possible complications.

I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR will be automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment.

I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

_____ _____ / _____ / _____

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices Pursuant to HIPPA and Consent for Use of Health Information

I received a copy of the Notice of Privacy Practices of Chattanooga Periodontics and Dental Implants in accordance with the Federal requirements of HIPAA. I Hereby authorize, as indicated by my signature below, Chattanooga Periodontics and Dental Implants to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the General Patient Consent form above.

_____ _____ / _____ / _____

Signature Date

_____

Print name