DENTAL OFFICE POLICIES: FINANCIAL, CONSENT FOR TREATMENT, INSURANCE, TEXTING, HIPAA ACKNOWLEDGEMENT

Consent for treatment

It is important to us that you, our patient, understand the treatment we are recommending and any procedures we may, with your agreement, perform. We want to involve you in all decisions concerning procedures you may need. So please sign this form only if you understand that there is a risk associated with dental procedures, and all your questions have been answered.

Dental treatment and procedures are generally safe but there is always a risk for complications. Any time you receive dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. Even a minor procedure like "fillings" can lead to major complications that cannot be foreseen. For example, "Novocaine" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but it's important to know risks can occur before consenting to treatment.

Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to hot and/or cold. These complaints usually go away without further treatment, but not always. In general, complications can include but are not limited to pain, swelling, bleeding, infection, and other nerve problems. I have read, understand and consent to dental treatments.

Initials: _____ Date:_____

SMS Privacy Policies/Terms and conditions

KENNETH E KAY, DMD, LLC respects your privacy and IS committed to protecting the information you shared. For instance: Non sharing Clause: KENNETH E KAY, DMD, LLC does not share your data with third parties for marketing purposes. KENNETH E KAY, DMD, LLC will not sell rent or share the collected mobile numbers. Data Collection: We will collect your name, email address, mailing address, and mobile phone number when you sign up for SMS updates. The information will be collected via this paper form. **By signing this form, I agree to opt in to receive texts from KENNETH E KAY, DMD, LLC**

- Data Usage: We use your data solely for sending updates and reminders related to our confirmations and cancellations of dental appointments, notifications about dental work that needs to be scheduled, information on dental health issues that may affect patients personally, and updates on office situations such as closures due to weather or holidays. Message frequency may vary, with an average of 1-2 messages per month.
- Data Security: We protect your data with secure storage measures to prevent unauthorized access.
- Data Retention: We retain your information as long as you are subscribed to our SMS service. You may request deletion at any time.
- MESSAGE AND DATA RATES MAY APPLY. Your mobile carrier may charge fees for sending or receiving text messages, especially if you do not have an unlimited texting or data plan. Messages are recurring, and message frequency varies based on communication needs.

- Opt in Messaging: Thank you for opting in to receive recurring messages from Kenneth E. Kay, DMD, LLC. Msg frequency varies. Msg & data rates may apply. with an average of 1-2 messages per month Reply HELP or INFO for help. Reply STOP to opt out.

- To get help, reply HELP Thank you for reaching out to Kenneth E. Kay, DMD, LLC. Please call us at +1 478-986-1830 or email us at info@drkaydentist.com for support. Reply STOP or UNSUBSCRIBE to opt out.

- To Opt-Out of messaging: Thank you for opt in to receive recurring messages from Kenneth E. Kay, DMD, LLC. Msg frequency varies. Msg & data rates may apply. with an average of 1-2 messages per month Reply HELP or INFO for help. Reply STOP to opt out.

Policies can be found here on the website: **https://drkaydentist.com/elementor-2021/.**

Initials: _____ Date:_____ Phone # to opt in to receiving text messages: _____

HIPPA Notice of Privacy Practices Acknowledgement

I have received this practice's HIPPA Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.
Initials: _____ Date: _____
Relationship to patient (if signed by a personal representative of patient):_____

Financial Policies

Thank you for choosing Kenneth E. Kay, DMD, LLC. 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 as possible by offering several payment options.

Payment Options: You can choose from: Cash, Check, Visa/MasterCard/Discover

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care.

Convenient Monthly Payment options are available from CareCredit Healthcare Credit Card (subject to approval):

- Allow you to pay over time
- No annual fees or pre-payment penalties

For plans requiring multiple appointments, alternative payment arrangements may be provided.

Insurance information:

For those with dental insurance, as a courtesy to you, we are happy to work with your carrier to maximize your benefits and we will directly bill them for reimbursement for your treatment. However, please understand that our relationship is with you and not your insurance company. We are happy to attempt to verify insurance coverage from the information you provide. We will estimate what your balance will be, and every though you pay your estimated patient balance, that may differ from what your insurance company ultimately pays. Unfortunately, not all services are covered benefits and some insurance companies arbitrarily select certain procedures they will not cover, so we cannot make guarantees of coverage or payment. If the insurance company refuses to pay for any treatment you will be responsible for the balance.

If you have secondary insurance, we will provide you with all the information you need to submit the claim.

Insurance policy info:

Subscriber Name:_____ DOB:_____ Social Sec #: _____ Insur ID#: _____

Employer: _____

Patient Name: _____ Patient DOB: _____ Patient Soc Sec #: _____ Relationship to policy holder: _____

Please note: Kenneth E Kay, DMD, LLC requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

We reserve the right to charge a fee of $50 for patients who miss or cancel more than 2 times in a 12 month period without 24 hour notice.

A fee of $35 is charged for all returned checks.

Assignment of benefits: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental

services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE POLICIES, INCLUDING THE FINANCIAL, CONSENT FOR TREATMENT, INSURANCE, TEXTING POLICIES and the HIPAA ACKNOWLEDGEMENT.

_____ _____

Signature Date

_____ _____

Signature of responsible party Date

_____

Please print your name