Dental Office Policy

The following is intended to familiarize you with our office policy and the various options for paying for you and your family's dental treatment.

Some patients may require major dental care while some may require minor care, and some will require routine maintenance care. Whichever you are in need of our office is dedicated to giving you the best possible care available. In order for us to accomplish this we must work together as a team.

Our day begins with your appointment! We have limited amount of appointment time, and your time has been reserved just for you. The dental appointment represents a shared responsibility of both the doctor and patient. In order to give quality dental care at an affordable cost, these appointments must be kept. If there is a problem with your appointed time, please give us at least a 48 hour notice to fill that time for someone else who may need to come in. **There will be a $50 .00 charge for broken appointments if we are not notified.**

An individual, written treatment plan will be prepared for each patient. This informs you of the necessary treatment that you require to restore your dental needs, and also to let you know what it will cost to complete this treatment. We will thoroughly review the treatment plan with you to ensure that you understand completely what your treatment will be and the cost of your treatment. There are prescribed sequences for rendering some dental services and we will follow these sequences unless there is a clinical reason for not doing so. Also, dental care may involve both charge and no-charge services, depending upon your dental coverage.

We happily file your dental insurances for you as a courtesy, but ultimately you are responsible for seeing that your account is paid for as promptly as possible! When you have dental coverage, you are required to pay your percentage/deductible at the time services are rendered! If you do not carry dental insurance you may choose to pay by:

____1. Pay all amounts owed by check or cash at each visit. (There is a $20.00 charge for returned checks.)

____2. Pay all amounts owed by credit card at each visit. We will accept Discover, Visa, Master Card, and Dencharge (Dental Credit Card).

I have read and understand the above treatment alternatives and have chosen the option indicated by my initials above. I understand that no treatment will be performed until financial matters are agreed upon. Also, in the event that this account is turned over for collections, for suit or otherwise, the undersigned agrees to pay all costs of collection, including reasonable attorney's fees.

_____ _____

Patient Signature Date

Dr. Robert J. Clark, DDS, 5612 Brainerd Road, Suite 100, Chattanooga, TN 37411, 423-485-1000

Notice of our Privacy Practices

Your Rights
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records, psychotherapy motes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on **April 14, 2003**.

We may from time to time call you or send you a notice in the mail via postcard regarding your appointment.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____ **Signature:**_____
Date:_____

Dr. Robert J. Clark, DDS, 5612 Brainerd Road, Suite 100, Chattanooga, TN 37411, 423-485-1000

Consent for Local Anesthetic Injections

I, (print name) _____, hereby authorize Dentist/Hygienist/Other (print name) Dr. Robert J. Clark to perform a local anesthetic injection(s).

I understand, and it has been explained to me, that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur they might include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs it is often temporary, and normal sensation usually returns in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

I have been told that success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication, and reporting to the office any change in my health status.

I acknowledge that no guarantee or assurances have been given by anyone as to the results that may be obtained.

I have discusses all of the above with the doctor, and have had all of my questions answered.

_____ _____

Patient Signature

If Minor, Signature of Parent of Guardian

_____ _____

Witness Signature

Dentist/Hygienist/Other Signature

_____

Date

Dr. Robert J. Clark, DDS, 5612 Brainerd Road, Suite 100, Chattanooga, TN 37411, 423-485-1000

ROBERT J. CLARK, D.D.S.
GREATER BRAINERD DENTAL
5612 Brainerd Rd., Ste. 100
Chattanooga, TN 37411
Phone: (423) 485-1000

Personal Health Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of any and all information including the diagnosis, financial and dentalrecords; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] please leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at the other numbers if unable to contact me at my requested number/location.

Signed: _____ Date: ____/____/____

OralID
Shine Light. Save Lives.

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

☐ Yes, I request that your staff perform an examination with the OralID.

_____	_____	_____
Signature	Name	Date

☐ No, I prefer to not have this examination at this visit.

_____	_____	_____
Signature	Name	Date

$25 Co-Pay