Patient Consent-Adult

Clinical

Upon my approval, I authorize **Jennifer J. Kalochie, DMD P.C.** to perform all recommended treatment, including but not limited to radiographs, study models, photos and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis; the use of local anesthetics and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness and/or lack of coordination.

Financial

I am responsible for payment for all services rendered. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR will automatically be 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.

Maintaining Appointments

I am aware that when appointments are broken or cancelled at the last minute, valuable clinical time is voided, time that could have been spent serving another patient, especially a patient in pain. ***A $50 missed appointment fee will be charged to my account for all missed appointments or last-minute cancellations by me.*** I am aware that to hold down operating costs, 24-hour notice of cancellation is required.

Insurance

I authorize **Jennifer J. Kalochie, DMD P.C.** 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 **Jennifer J. Kalochie, DMD P.C.** the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

HIPAA Acknowledgment

I authorize **Jennifer J. Kalochie, DMD P.C.** to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, specialty dentists involved in my care, any and all information, records and other diagnostic material about my medical history, services rendered or recommended treatment.

I acknowledge receipt of the **Notice of Privacy Practices**.

I authorize sharing my protected health information with the following individuals who may be involved in my care and I understand I am responsible to notify **Jennifer J. Kalochie, DMD P.C.** of any changes:

Name: _____Contact Number:_____

Name: _____Contact Number:_____

You may contact me personally at the following phone number/email address:

Home Number: _____to include a voice message

Mobile Number:_____to include a text and voice message

Email: _____Other:_____

Patient (over 18) Signature: _____ __Date:_____