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COVID-19 Pandemic Dental Treatment Consent and Release

The goal of our practice is to provide a safe environment for our patients and staff, and to advance the safety of our community. However, the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. There are numerous ways in which the COVID-19 virus can be transmitted, including surfaces that contain the virus, respiratory droplets from someone who is infected with the virus, and aerosols, which are fine particles that can stay suspended in the air for hours and can travel with air currents, generated by someone infected by the virus. Dental procedures create aerosol, the amount of which depends on the type of dental procedure performed. While we are committed to providing the safest environment as possible for our patients, there can be no guaranty that our facility is completely free of the COVID-19 virus and that you will not be exposed to the virus while receiving dental treatment despite our efforts to minimize the risk of exposure.

By signing this Consent and Release in the space provided below, you hereby release, acquit, waive all claims against, and forever discharge the practice providing my treatment (the "Practice") and its owners, successors, assigns, affiliates, officers, directors, administrators, representatives, principals, agents, servants, dentists, employees, independent contractors, insurers, and attorneys (collectively with the Practice, the "Indemnified Persons"), of and from any and all claims, charges, demands, promises, acts, agreements, costs, damages, debts, obligations, actions, causes of action (including but not limited to all avoidance actions of any type), suits in equity, expenses, executions, judgments, levies, liabilities, losses, and attorneys' fees, of whatever kind or nature, whether legal or equitable, liquidated or unliquidated, fixed or contingent, direct or indirect, suspected or unsuspected, accrued or unaccrued, known or unknown, present or future, asserted or unasserted, based upon, arising out of, appertaining to, or in connection with your exposure to the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) or contracting coronavirus disease (COVID-19) as a result of or in connection with your entry into the Practice's office, receipt of dental treatment from the Practice or coming in contact with any Indemnified Person at or near the Practice's office, and all related costs, expenses, illness, or death you may suffer as a result.

The releases set forth and otherwise referenced herein shall be interpreted as broadly as possible and shall be completely binding and enforceable at law. You acknowledge that the releases and waivers provided for herein include all claims and/or costs, including but not limited to those you do not know or suspect to exist, and hereby waive all rights which may exist with regard to such claims and/or costs. You expressly waive the provisions of any federal, state, and local statute or regulation limiting release of unknown claims, including any statutory language stating as following: "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY, AND ANY SIMILAR LAW."

You agree that you have had the opportunity to consult with an attorney prior to executing this Consent and Release, that you voluntarily have signed the same and that you have read and understand this Consent and Release. YOU FULLY UNDERSTAND THAT, BY SIGNING THIS CONSENT AND RELEASE, YOU ARE WAIVING IMPORTANT LEGAL RIGHTS.

ENDODONTIC TREATMENT CONSENT FORM

We want to inform our patients about the various procedures involved in Endodontic Therapy and have their consent before starting treatment. Endodontic (root canal) Therapy is performed to save a tooth which otherwise might need to be removed.

Endodontics or root canal therapy is the cleaning, shaping, disinfecting, and filling of the root canal(s) of the diseased tooth. Endodontic therapy is accomplished by using a local anesthetic to numb the tooth involved. A minimal number of x-rays will be taken as indicated by the type of treatment.

Endodontics, as with any branch of medicine or dentistry, is not an exact science. Thus, no guarantee of treatment success can be given or implied. If the original treatment is not successful, it may need to be retreated, a surgical procedure may be required, or the tooth may need to be extracted.

This therapy is considered to be very safe, successful and effective. Nevertheless, we want you to be aware of the risks and consequences of having endodontic therapy performed.

I understand there are certain **potential risk in the procedure.** These include:

1. Inability to completely fill the root canal because the canal is calcified or has a unique curvature.
2. Infection that may occur and may continue, requiring further endodontic surgery or extraction.
3. Fracture or breakage of the root or crown portion during or after treatment.
4. Inadvertent separation of files or instruments that cannot be retrieved within the root canal system.
5. Perforation of the tooth during treatment.
6. Damage to existing fillings, crown, or porcelain veneers.
7. Paresthesia (temporary numbness or possibly permanent numbness) resulting from root canal therapy.

OTHER POSSIBLE TREATMENT CHOICES AVAILABLE TO ME: These include no treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

I certify that I have read and understand the above Notice of Privacy Practices, Payment Policy, and Endodontic Treatment Consent Form. I accept all risk, if any, in hope of obtaining the desired beneficial results. I acknowledge that the dentist has explained all of the above to me in a manner to allow me to comprehend the consequences of my actions. Any questions about this treatment plan and its attendant risk have been answered fully and to my complete satisfaction.

PAYMENT POLICY

We believe that you are entitled to know the cost of our services before making your decision regarding treatment. If we have not discussed our fees with you in advance of your visit, please ask us before you are seated for your appointment.

PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE.

For your convenience, we accept MasterCard, Visa, Discover, American Express or Care Credit. We also accept personal checks and cash.

DENTAL INSURANCE

1. Fees are due in full if your insurance does not assign (send) benefits to us.
2. We are glad to file your claim as a courtesy to you.
3. Your benefits are a contract between you, your employer and insurance company.
4. Not all dental services are covered by every dental plan.
5. Deductibles and co-payments are due at time of service. ALL CO-PAYMENTS ARE ESTIMATES ONLY AND NOT A GUARANTEE OF PAYMENT. You may have a balance due after your insurance has paid. If you have a balance it is due in full upon receipt of invoice. We do not have payment plans.
6. We expect payment from your insurance within 60 days. After 60 days the balance is payable in full by you.
7. PARTIAL PAYMENTS WILL NOT BE ACCEPTED.
8. If your insurance pays more than expected, we will refund the difference to you.
9. If you feel your insurance made an error, you are still responsible for any balance due to this office. You must contact your insurance company for an explanation.

I have read the above payment policy and understand that I am responsible for all cost of my dental treatment.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect upon signing and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to a authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, at this time we do not charge you for per page or hourly for staff time to locate and copy your health information or for postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Signature of Patient or Responsible Party