

PATIENT CONSENT – ADULT

Clinical

1. I authorize Vibe Dental to perform all recommended treatment including but not limited to:
 - a. All recommended treatment.
 - b. Radiographs, study models, photos, and other diagnostic aids or materials (collectively, “Diagnostic Material” as needed to make a thorough diagnosis.
 - c. The use of anesthetics, nitrous oxide, sedatives, and other medication, as needed, and I 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

2. I am responsible for payment for all services rendered. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

Maintaining Appointments

3. A \$50 missed appointment fee could be charged to my account for all missed appointments or last-minute cancellations. I am aware that 24-hour notice of cancellation is required.

Insurance

4. I authorize the practice to submit claims for payments 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.

HIPPA Acknowledgment

5. I authorize the practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, specialty dentists involved in my child’s care, any and all information, records, and other diagnostic material about my child’s medical history, services rendered, or recommended treatment.
6. I acknowledge receipt of the Notice of Privacy Practices and authorize the practice to use and disclose my protected health information for any clinical, financial and insurance purposes.
7. I authorize sharing my protected health information with the following individuals who may be involved in my child’s care, and I understand I am responsible to notify the practice of any changes:
 - d. Name: _____ Relationship/Phone Number: _____
 - e. Name: _____ Relationship/Phone Number: _____
 - f. Name: _____ Relationship/Phone Number: _____
8. I authorize the following means of communication:
Home Number: _____ to include a message
Mobile Number: _____ to include a text message and voice message
Email: _____ Other: _____

Patient Signature: _____ **Date:** _____

Individual refused to sign