

GENERAL DENTISTRY INFORMED CONSENT

CHART NUMBER _____

NAME _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings_____, Bridges_____, Crowns_____, Extractions_____, Impacted teeth removed_____, I.V. Sedation_____, Root Canals_____, Other_____. (Initials_____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphalactic shock (severe allergic reaction). (Initials_____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials_____)

5. CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. I further understand that my gingiva (gums) will be sore until healing time has elapsed and that during this healing time my gingiva around the tooth being capped will shrink (recession), sometimes making the tooth look longer than the natural tooth. (Initials_____)

6. DENTURES - COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating dentist nor Saddleback Dentistry is responsible for my dental treatment.

Signature: _____ Date: _____

Doctor: _____ Witness: _____

LYDON DENTISTRY
Cosmetic and General Care

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4250 Scott Dr. Suite J * Newport Beach, CA * 92708
P: 949.660.1321 * E: Info@Lydondentistry.com * F: 949.851.0856

Financial Policy and Agreement and Cancellation Policy

Welcome to Lydon Dentistry and thank you for choosing our office for your dental needs. We understand that insurance and financial matters can be complex at times. Our knowledgeable staff will be available at any time to help you.

Your payment is due at time of service. We accept cash, check, Visa, MasterCard, and CareCredit.

If you are covered by a dental insurance plan, please provide our staff with your correct and current insurance information. We will file the appropriate claim forms with your insurance company, provided that you supply us with personal information including social security number/subscriber ID number and date of birth. We will process your insurance claim as a courtesy to you, the patient; however, it is your responsibility to make sure your account is paid in full.

Some insurance carriers pay from a fee schedule that might be lower than our “usual and customary” fees, then it is the patient’s responsibility to pay the difference in fees at the time services are rendered. The difference in fees reflects the level of contractual benefits purchased by your employer with a particular dental insurance carrier. Our fees are based on the usual and customary fee schedules approved by California Dental Services.

Occasionally, your insurance carrier will choose to deny coverage for procedures that are performed. If this happens, we will provide you with any appropriate documentation so that you can persist in your insurance claim.

If your insurer denies coverage, or if we otherwise do not receive payment **within 60 days** from date services are rendered, the amount will then become due and payable by you. Please remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. Although we will make every effort to help you obtain your benefits, we cannot **guarantee** your insurer will pay.

The patient’s responsibility is not modified by whether any third party (insurance) pays for all, part or none of the charges. If the balance on the patient’s account is not paid within 30 days of statement, the account will become delinquent and will be forwarded to a third party collection agency. If this becomes necessary, additional fees may be added to cover handling charges.

Cancellation Policy

We are committed to seeing our patients on time and respecting their time. Late cancellations (less than 48 hours notice), failed appointments, and late arrivals are disruptive to our schedule and to other patients.

In order to maintain our schedule we request 48 hours notice for cancellations or rescheduling of appointments. In the instances of a late cancellation (less than 48 hours notice) or failed appointment there may be a charge of \$35-\$75 depending on the scheduled treatment.

Sung Lydon, D.D.S.

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 04/14/03, 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 students, healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and 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 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 practicably 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, we will charge you \$1.00 for each page, \$0.00 per hour for staff time to locate and copy your health information, and 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.

Contact Officer: **Summer Alvarez**

Telephone: **(949) 660-1321** Fax: **(949) 851-0856**

E-mail: **Info@LydonDentistry.com**

Address: **4250 Scott Dr. Suite J, Newport Beach, CA 92708**



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**Acknowledgment of Receipt of Notice of Privacy Practices and
Financial/Cancellation Policy**

I acknowledge that I have received a copy of the Statement of Privacy Practices and Financial/Cancellation Policy for the office of Sung Lydon, D.D.S.

I acknowledge my responsibility for payment of services rendered by and in accordance with Sung Lydon, D.D.S. fees and terms. I agree to the terms as described in the Financial/Cancellation Policy.

The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that might occur in my treatment, payment of services, or in the performance of office health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of the office with respect to my protected health information.

Name of Patient or personal Representative

Date

Signature of Patient or Personal Representative

Date

