Informed Consent for Controlled Substance Therapy for Pain

In Nevada, per Assembly Bill 474, prescribers must inform their patients of information regarding the treatment of pain with the use of a controlled substance. It is important that you review the following information carefully and request additional information you may need to make an informed choice about the mediation(s) prescribed. Please review the information listed here and initial each item.

____ I understand that I am being prescribed medications, including controlled substances for the treatment of pain.

____I understand that all pan medications, including controlled substances, have different benefits and risks in the treatment of my symptoms. I have been advised of the potential risks and benefits of treatment using controlled substances.

____I understand that prescription controlled substances can carry serious risks of addiction and overdose, especially with prolonged use.

____I understand that I am not to use the controlled substance prescribed to me in conjunction with drugs or alcohol, or other medications (unless otherwise directed by my prescriber.)

____Before I was prescribed the pain medication, I was advised regarding non-opioid alternative means of treatment for my symptoms, including but limited to anti-inflammatories (i.e., Aleve, Tylenol, Ibuprofen, etc.).

____I understand that when I take controlled substances(s), it may not be safe for me to drive a car, operate machinery, or take care of other people. I fell sedated, confused or otherwise impaired by these medications, I understand that I should not do things that would put myself or other people at risk for being injured.

____I understand that when I take controlled substances, I may become physically dependent on them, meaning my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

____I understand that I may become addicted to controlled substances and require addiction treatment if I cannot control how I am using them, or if I continue to use them for a prolonged period of time. I have discussed with my prescriber the proper use of the controlled substance.

____I understand that anyone can develop an addiction to pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past or who have a parent or sibling who has had drug or alcohol abuse problems are at higher risk. I have told my prescriber if I or anyone in my family has had any of these types of problems.

Desert Valley Dental	3665 Lakeside Dr. Reno, NV 89509 775-825-1055
Dr. Robyn Goodman	5990 Silverlake Rd. Reno, NV 89506 775-971-3971
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Dr. Joseph Eberle	5295 Sun Valley Blvd. Suite 6 Sun Valley, NV 89433 775-673-1055

____I understand that I must store prescriptions in a secure place and out of the reach of children, other family members and others and/or use a locked medicine cabinet. I safely dispose of unused medications, I can return the unused medications in the bottle to a local pharmacy, a local drug-take back day, or a local police or sheriff substation in my community, or I may safely dispose of them by dissolving them in a Dettera pouch. I understand that I am not to dispose of unused medications into the toilet or sink.

____I understand that my doctor may not be permitted to refill my medication via telephone and, therefore, any requests for refills may require a consultation appointment. I understand that my doctor may decline to refill my prescription if s/he believes it to be medically unnecessary and/or harmful to my well-being. I understand that I am being prescribed a controlled substance for a short duration and that prescriptions for additional periods of time may require additional consultation, assessment and agreements.

____I understand that due to risk of possible overdose resulting from controlled substances, the opioid overdose antidote naloxone (Narcan) is now available without a prescription. I may obtain naloxone (Narcan) from the pharmacist.

____For Women: It is my responsibility to tell my prescriber immediately if I think I am pregnant or if I am thinking about getting pregnant. I understand the risk to a fetus of chronic exposure to controlled substances during pregnancy, including, without limitation, the risks of fetal dependency on the controlled substance, neonatal abstinence syndrome, neurologic and heart problems in the baby, prematurity, and fetal or neonatal death.

Informed Consent:
I understand each of the statements written here and by signing give my consent for treatment of my pain condition with medications, including controlled substances. I have had the opportunity to ask any questions that I may have regarding my treatment of pain with medications, including controlled substances, and am satisfied that my questions have been ansered.

_____	_____	_____
Patient Name Printed	Patient Signature	Date

Un-emancipated Minor
As the Parent/Guardian, I have discussed with the prescriber the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion.

_____	_____	_____
Parent/Guardian Name printed	Parent/Guardian Signature	Date

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Welcome to the Dental Practice of Joseph J. Eberle D.D.S.

Patient Financial and Privacy Policies

We are proud to be part of a team whose primary goal is to provide the finest and most comprehensive dental care available today. It is important that you read and understand our office policy and ask any questions you may have regarding any of the following.

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE UNLESS YOU ARE AN *ESTABLISHED* PATIENT OF RECORD AND ONE OF THE FOLLOWING OPTIONS APPLIES AND IS SELECTED.
Established: Full exam and full mouth x-rays

_____ 1. (*For Established Patients without or not utilizing Insurance.) I choose to pay my balance in full at time of service and take advantage of a 10% courtesy discount.

_____ 2. (*For Established Patients with Insurance.) I choose to pay my estimated portion at each appointment. I understand that any remaining balance not paid by my dental insurance is my responsibility to pay in full within 30 days of insurance receipt or denial.

_____ 3. I choose to use CareCredit® for any services over $300 and take advantage of their 0% interest programs. (Subject to Credit Approval)

REGARDING INSURANCE:

We will gladly process your insurance claims, estimate your deductible and portion not covered by your insurance plan. The estimated amount not covered by your insurance is due at the time of treatment. Our estimates are not a guarantee of coverage or benefits and should not be taken as such. The balance is your responsibility whether your insurance pays it or not. If you have dual insurance we will bill the secondary insurance after primary payment has been received. We do this as a courtesy for you. However, you should be aware that many secondary insurance plans no longer cover amounts unpaid by your primary insurance. Therefore, patients must pay the estimated amount not covered by the primary insurance at the time of service.

REGARDING APPOINTMENTS AND CANCELLATIONS:

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

We feel that our patient's time is valuable. When your appointment is made, your records are prepared, and special instruments are readied for your visit. Except for an emergency, we pride ourselves for being on time and prompt, so we would appreciate the same courtesy from our patients.

There is a $50 Charge for not showing up for scheduled appointments, and or canceling appointments with less than 24 hours notice. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

REGARDING PAST DUE AND DELINQUENT ACCOUNTS:

We will charge 1.58% MPR and 18.96% APR for all accounts over 90 days past due.

In cases it becomes necessary to hire an outside collection agency to collect moneys owed on accounts over 90 days, your balance will be increased by 40% to 50% to cover all collection/small claims court costs.

I, _____ authorize Dr. Joseph J Eberle, DDS, to examine and provide dental treatment.
I authorize my insurance company to pay by check made out directly to Dr. Joseph J. Eberle. I authorize Dr. Eberle to release any medical, dental or incidental information that may be necessary for either dental care or in processing applications for financial reimbursement. I understand that it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospitals, emergency rooms, laboratories, x-ray departments, and specialists which are assigned to me according to my insurance policy rules. It is Dr. Eberle's office procedure to share Protected Health Information with labs, consulting physicians, and hospitals. We will phone the pharmacy of your choice regarding your prescriptions. Only the minimum necessary Protected Health Information for each transaction will be exchanged.
A copy of our notice of privacy practices is available upon request.

X _____ Date _____.
Signature of Patient, Responsible Party or Legal Guardian.

Desert Valley Dental will not disclose any information about you or your account to any individual without written consent.

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") [42 C.F.R. § 164.500 *et seq.*]

Please review and complete the authorization carefully. Failure to provide all the requested information may invalidate the authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Desert Valley Dental to (check those that apply):
Name of Patient

____ use the protected health information described. (do not share information)

____ disclose the protected health information described below to: (ie: spouse, friend, sister)

_____
_____
_____

This authorization is limited to the following information relating to my past, present, or future condition:

____ **Complete health record(s)** for all date(s) of service, which may contain all documents

OR

____ **Records Specified Below**

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

____ Further Medical Care
____ Insurance Eligibility/Benefits
____ Legal Investigation or Action
____ Other (Specify): _____
____ Personal
____ Changing Physicians
____ Product/Service Communications

EXPIRATION

This authorization shall be in force and effect until _____ **[specify (1) date or (2) event that relates to the patient or the purpose of the use or disclosure]** at which time this authorization to use or disclose this protected health information expires.

PATIENT RIGHTS

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Desert Valley Dental. I understand that a revocation is not effective to the extent that Desert Valley Dental has relied on the use or disclosure of the protected health information.

Desert Valley Dental will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, unless as otherwise specifically allowed by law.

I understand that HIPAA prohibits the recipient of my health information from making further disclosures of it without obtaining an additional authorization from me, except in cases in which a further disclosure is permitted or required by law.

I understand that I have a right to receive a copy of this authorization upon my request. In addition, if Desert Valley Dental has sought this authorization, I must be provided with an executed copy of the authorization, whether or not I specifically request one.

SIGNATURE

_____

Signature of Patient or Personal Representative

_____

Date

_____

Print Name of Patient or Personal Representative

If signed by a Personal Representative of the Patient, describe the representative's authority to act for the patient:

_____

_____

Today's Date _____ Updates _____ | | | | | |

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ SSN _____

Employer _____ Address _____ Phone _____

Nearest Relative _____ Address _____ Phone _____

Email Address _____ Referred by _____

(Insurance List, Friends Name, Yellow Pages, etc.)

SPOUSE OR RESPONSIBLE PARTY (Circle One or Both)

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ SSN _____

Employer _____ Address _____ Phone _____

HEALTH QUESTIONNAIRE (Please indicate if you have or have had any of the following. Check or circle where applicable)

☐ **Taking Blood Thinners / Aspirin**	☐ **Heart Valve Replacement**	☐ **Bleeding Disorder**
☐ Glaucoma	☐ Asthma	☐ Thyroid disease
☐ History of Drug Dependency	☐ **Heart Surgery**	☐ Stroke / Aneurysm
☐ Tuberculosis	☐ Osteoporosis Medication	☐ **Hepatitis**
☐ Currently Pregnant	☐ Surgery for Artificial Parts	☐ Cancer or History of Cancer
☐ Cardiac Pacemaker	☐ Sinus Problems	☐ **AIDS / HIV**
☐ **Heart Attack**	☐ **Joint Replacement**	☐ Radiation therapy
☐ Kidney / Liver Disease	☐ Epilepsy	☐ **I.V. Cancer Medications**
☐ **Heart Defect**	☐ **High Blood Pressure**	☐ Diabetes
☐ History of Steroid Therapy	☐ Emphysema	☐ **Paget's Disease**

Are you taking any **medications** and/or **required medications**? . . . . . **YES / NO**
If so, please list _____

Are you **allergic** to any medications or materials *(penicillin, latex, epinephrine, fluoride, etc.)*? . . . . . **YES / NO**
If so, please list _____

Do you have any disease, condition or problem **not listed** on this form? . . . . . **YES / NO**
If so, please explain _____

Do you use tobacco products? . . . . . **YES / NO**
If so, what and how much? _____

Have you ever been instructed by a physician to **pre-medicate with antibiotics** prior to dental treatment? . . . . . **YES / NO**

CONSENT FOR TREATMENT:

I authorize the dentist, and/or other dental providers consent to perform the treatment and whatever procedures may be deemed necessary or advisable in addition to the planned treatment. I understand that there could be complications in connection with the dental procedures such as swelling, bruising, infection, tingling and/or numbness of the lips, tongue, gums, and/or face, which may be permanent; damage to root or tooth in sinus; oral antral fistual; maxillary sinusitis; and post operative hemorrhage and discomfort. I agree to the use of local anesthetic, sedation and analgesia depending on the judgment of the dentist. I understand that there are possible complications, risks and benefits of treatment, anesthesia, other drugs and medication. I have answered this form to the best of my knowledge and have had all my questions answered to my satisfaction. I authorize treatment and the payment of insurance benefits to the practice.

Patient or Authorized Person's Signature **Date**