Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment for all dental services. This office will help prepare the patient insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____	_____	_____
(Signature of patient, parent, or guardian)	(Date)	(Relationship to patient)
_____	_____	_____
(Signature of guarantor of payment)	(Date)	(Relationship to patient)

***I authorize Mahant Dental, LLC/ Mableton Family Dentistry, doctors, and staff to communicate with me by the following methods regarding appointments or needed treatment. I understand that I may also revoke permission to communicate by the means indicated below, at any time, either verbally or in writing.**

Postcards _____Yes _____No **Text Message** _____Yes _____No

Email _____Yes _____No **Voicemail** _____Yes _____No

I also authorize Mahant Dental, LLC/ Mableton Family Dentistry, doctors, and staff to communicate with the persons listed below concerning my care. I understand that I may also revoke permission to communicate with these individuals as listed below, at any time, either verbally or in writing. *Please list name, contact number, and relationship:

1._____

(Name) (Contact #) (Relationship)

2._____

(Name) (Contact #) (Relationship)

Signed:_____ Date_____

(Signature of patient, parent, or guardian)

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____understand that as part of my health care, Mahant Dental, LLC/Mableton Family Dentistry and any associates, may originate and maintain paper and/or electronic records describing my dental and medical health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that I have the following rights and privileges:

- The right to review Mahant Dental, LLC's/Mableton Family Dentistry's ***Notice of Information Practices*** that provides a complete description of the uses and disclosures prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

These rights are given to me under the ***Health Insurance Portability and Accountability Act of 1996 (HIPPA).***

I understand that Mahant Dental, LLC/Mableton Family Dentistry is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing, except to the extent that the organization has already taken action. I also understand that by refusing to sign this consent, or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Mahant Dental, LLC/Mableton Family Dentistry reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I understand that I may contact you at any time to obtain the most current copy of this notice.

I understand that as part of Mahant Dental, LLC's/Mableton Family Dentistry's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and email.

Signed: _____ Date: _____

(Signature of patient, parent, or legal guardian)

Thank you for choosing our office to assist you with your dental needs. Please fill out the following information and provide your signature.

Patient's name:_____ Preferred Name:_____ DOB:_____

Gender: _____ If minor, name of legal guardian:_____

Home phone: _____ Mobile Phone: _____

Work Phone: _____ Email: _____

Mailing Address: _____ City:_____ State:_____ Zip:_____

Employer_____

Whom may we thank for referring you to our office? _____

Insurance Information:

Your SS#: _____ *or* Member ID#: _____

Dental Insurance Company:_____ Group #: _____ INS Company #:_____

Covered by Spouse's Insurance? YES/ NO Spouse's Name:_____ Spouse's DOB:_____

Medical Health History: (Do you have, or have you had any of the following? Check all that apply.)

Are you required to Premedicate before any dental treatment? If yes, why?_____

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes Type 1 or Type 2
- ☐ Emphysema
- ☐ Epilepsy or seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Hay fever/Sinus trouble
- ☐ Heart Attack/Failure
- ☐ Heart Murmur/MVP
- ☐ Heart Pacemaker
- ☐ Heart Disease
- ☐ Hepatitis A, B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Care
- ☐ Radiation
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tumors
- ☐ Tuberculosis
- ☐ Tumors

ALLERGIES?

- ☐ Penicillin/any other antibiotics
- ☐ Sulfa Drugs
- ☐ Local Anesthetics
- ☐ Aspirin
- ☐ Codeine/other narcotics
- ☐ Metal
- ☐ Other:

Current Medications:

Medication/Dosage	Condition
1._____	
2._____	
3._____	
4._____	
5._____	
6._____	
7._____	
8._____	
9._____	
10._____	

Name/ # of Primary Medical Physician:

Women: Are you pregnant or trying to get pregnant? ___ Yes ___ No Taking Oral Contraceptives? ___ Yes ___ No Nursing ___ Yes ___ No

Do you smoke, Vape, or use tobacco products?

Signature_____ Date_____

To My Appreciated Patient,

This year marks the beginning of many exciting changes. Our vision is to create a warm, welcoming, and family-oriented environment that offers quality dental health care. We expect, every day, as your team of caring and honest professionals, to earn the loyalty and trust of patients, who will, in turn, appreciate our value and time. We are committed to your overall health and well-being. We focus on patient education and offer choices of available care, which will impact your health in a positive way. Therefore, the following must be agreed upon:

1. *No-shows are not acceptable*. Failure to show for an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot keep an appointment (except in case of an emergency) you are expected to call within 48 hours of your appointment to reschedule. There is a $100 fee for all no-show appointments. This fee is not covered by insurance. A portion of this fee will be donated to Children's Healthcare of Atlanta.

2. *We request that you be on time for your visits*. If you are more than 10 minutes late, you will have to reschedule your appointment.

3. *If you miss an appointment, we ask that you call to reschedule within 48 hours*. It is crucial to your health to do so to avoid setbacks in your oral health.

4. *Insurance*: treatment recommendations are based on your health not your insurance or lack thereof. If you have insurance, it is your responsibility to be aware of your benefits. Remember, insurance companies are not concerned about your health or well-being; we are. As a courtesy, we will provide you with an estimate of benefits; however, you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. As a reminder, we cannot be responsible for what your insurance will or will not cover.

5. *We run a ZERO balance office*. To achieve this, we require 50% of your out-of-pocket expense to reserve an appointment with Dr. Mit Brahmbhatt. Please speak with front office staff if you have questions regarding your financial options.

6. *Emergencies*: It is our goal to eliminate all potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency, we will provide you with the next available emergency appointment.

In closing, our goal is to create an exceptional experience every time you visit our office. Please feel free to discuss any issues that arise. No problem is too big or too small.

Yours in Health,

Dr. Mit Brahmbhatt, DMD

I have read and agree to the terms of the Appreciated Patient Letter.

Signed:_____ Date_____

(Signature of patient, parent, or guardian)