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Practice Limited to Endodontics

INFORMATION ABOUT AND CONSENT FOR ENDODONTIC TREATMENT

ENDODONTIC TREATMENT HAS BEEN RECOMMENDED. WHAT ARE MY ALTERNATIVES?

Endodontic treatment has been recommended as a procedure to be done on your tooth in an attempt to postpone the loss of a tooth that may otherwise require extraction. Your alternatives to the proposed treatment are to have no treatment done or to have the tooth extracted. If no treatment is done, there is the risk of infection, pain and loss of the tooth. If the tooth is extracted, then some form of an artificial replacement tooth may be constructed.

WHAT ARE THE POSSIBLE COMPLICATIONS?

Complications are rare. While no complications may be expected as a result of the proposed endodontic treatment, it is possible that complications may still occur with your care. Most of the complications that can occur are a normal consequence of treating teeth that have problems similar to yours. These complications may require additional treatment.

Some of the possible complications include but are not necessarily limited to the following possibilities: mild to severe pain, infection, swelling, fever, or difficulty opening or closing the jaw. The root canal itself is a very small chamber running through the root. Consequently, a procedural difficulty may be encountered such as a perforation or instrument breakage in the canal. A perforation is an artificial opening or canal that exits the side of the root.

Endodontic treatment is a highly successful procedure for postponing the loss of teeth that would otherwise be extracted. Unfortunately, not all teeth will respond favorably to the treatment. Consequently, it is possible that your tooth may in the future require additional treatment such as another endodontic treatment, surgery, or even extraction.

Medications may be given for pain or infection. If given pain medication, you cannot drive an automobile nor operate equipment that may be hazardous to yourself or others while under the influence of the pain medication. If you are a female who is taking birth control pills, it is possible that you could become pregnant while taking an antibiotic. Consequently, an alternative form of contraception may be appropriate 'while taking the antibiotic.

To protect your tooth from decaying or fracturing, you will need to return to your dentist for a permanent filling or crown. If the tooth has a metal or porcelain crown it may be necessary to make an opening in the crown to treat the root canal. When this is done, it is possible that some breakage of the porcelain may occur. While this is rare, there are variables beyond our control that may lead to breakage and we cannot be responsible for repair or replacement of porcelain,

CONSENT FOR TREATMENT

I hereby give consent to Dr. Wallstrom and Dr. Naini to perform Endodontic Procedures on me or my dependent and any such additional procedure(s) as may be considered necessary for my well-being based on findings made during the course of the treatment. The nature and purpose of the treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the treatment. I also consent to the administration of local anesthesia during the performance of the treatment.

Patient Name: _____ Date of Birth: _____

Procedure: _____ Signed: _____

Date: _____ Witness: _____

STATEMENT OF PRIVACY PRACTICES

AUBURN VALLEY ENDODONTICS

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

OFFICE PRIVACY PRACTICES AND FINANCIAL POLICY

- A $100 fee will be charged for any missed appointments, not canceled within 24 hours.
- A $40 fee will be charged for all returned checks.
- Fees for services vary depending on complexity of treatment and number of canals involved.
- Fees once quoted remain the same except: 1) When additional canals are found after the first procedure. 2) When irregularity in keeping appointments results in prolonged appointments. 3) When additional services are required such as surgery or retreatment.
- **Cash Patients: All fees are due at the time of service**
  Insured Patients: Your coinsurance is due at the time of service
- Accepted forms of payment are: Cash/Check, Visa, Mastercard, Care Credit
- A 1.0% service charge will be charged to balances over 90 days. ($1 Minimum)

All quotes of insurance responsibility are estimates only. The amount your insurance pays is between you and your insurance company. We are not responsible for insurance benefits paid that differ from the original estimate. All fees are your direct responsibility, we cannot render service under the assumption that our fees will be paid by your insurance company.

I understand that the fees incurred for dental treatment are my responsibility. I have read and understand the above information and accept that I am financially responsible for any/all balances due. If I have dental insurance, I authorize the dentist or insurance company to release any information for payment or review of this claim. I also authorize benefits to be paid directly to the dentist.

Patient Signature:_____ Date: _____

I acknowledge that I understand the Statement of Privacy Practices for the office of Auburn Valley Endodontics. The statement of privacy practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The statement of privacy practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The statement of privacy practices is also posted in the facility. Auburn Valley Endodontics reserves the right to change the privacy practices currently described in the statement of privacy practices. If privacy practices change, I will be offered a copy of the revised statement. I may also obtain a revised statement of privacy practices by requesting that one be mailed or otherwise transmitted to me. In addition to the allowable disclosures described in the statement of privacy practices, I hereby specifically authorize disclosure of my protected healthcare information to my general dental office.

Patient Signature:_____ Date: _____