HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day to day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complex description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these restricted restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at anytime. However, use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Agreement to Office Policies and Practices

I. MISSED APPOINTMENTS. Patients are required to provide no less than forty-eight (48) hours' advance notice if they are unable to attend a scheduled appointment. Notice must be given during regular business hours. Failure to provide the required notice, including same-day cancellations or failure to appear for a scheduled appointment ("no-show"), will result in a $100 missed appointment fee. This fee is assessed to compensate the practice for reserved clinical time and administrative costs, and to allow the opportunity to accommodate other patients in need of care.

The missed appointment fee may be waived in the event of a verifiable and unforeseeable emergency, at the sole discretion of the practice. Except in such circumstances, late cancellations and no-shows will be subject to the $100 charge.

II. SERVICE CHARGES. All consultation fees are non-refundable. A late fee of $50 will be assessed if payment is not received within two (2) weeks of the due date. A $30 service charge will be applied to any returned checks. The responsible party agrees to pay all costs incurred in the collection of past-due accounts, including reasonable attorney's fees. An administrative fee of $100 will be charged for processing any financing contract; however, this fee will be waived if the patient completes treatment in our office. A 20% cancellation fee will apply to any treatment financed through CareCredit, Chase, or Capital One in the event the treatment is canceled.

III. FINANCIAL CONSENT. I agree to be fully responsible for the total payment of all fees for professional service rendered by Aesthetic Smiles by Design, the office of Dr. Orffa Masso, DDS. I have read, understood, and fully agree to the terms and conditions set forth herein.

_____ _____

Financially Responsible Party Signature Date

_____ _____

Financially Responsible Party Printed Name Relationship to Patient

Consent for Dental Treatment

Dentist's Name: Dr. Orffa Masso, DDS

Patient's Name: _____

Responsible Party's Name (*if applicable*): _____ Relationship: _____

Please read & initial ONLY the checked procedures below, then proceed to sign.

☐ X-Rays: *I understand that dental radiographs (X-rays) are an important diagnostic tool used to detect conditions that may not be visible during a clinical examination. I acknowledge that X-rays involve a low level of radiation, and all precautions will be taken to minimize exposure. I consent to the taking of dental X-rays as deemed necessary by my dentist for diagnosis and treatment planning.*

Patient or Responsible Party Initials: _____

☐ Drugs & Medications: *I understand that, as part of my dental treatment, the prescribing of medications (including antibiotics, analgesics, anti-inflammatory drugs, or other necessary medications) may be recommended. I acknowledge that all medications carry potential risks and side effects, and I affirm that I have disclosed my complete medical history, including allergies and current medications. I consent to the use of such medications as deemed necessary by my treating dentist and agree to take them only as prescribed.*

Patient or Responsible Party Initials: _____

☐ Changes in Treatment Plan: *I understand that during the course of my dental treatment, unforeseen conditions may arise that require modifications to the original treatment plan. I acknowledge that such changes may affect the type, extent, or cost of treatment. A common example of this would be the need for root canal therapy or tooth extraction discovered during or after restorative procedures. I consent to any necessary adjustments deemed appropriate by my dentist to ensure safe and effective care, and I understand that Dr. Orffa Masso, DDS will discuss any changes with me whenever it is feasible and safe to do so.*

Patient or Responsible Party Initials: _____

☐ Removal of Teeth: *I understand that the removal of a tooth does not always eliminate an existing infection and that additional treatment may be required. I acknowledge that tooth extraction carries certain risks, including but not limited to pain, swelling, bleeding, infection or spread of infection, dry socket (alveolar osteitis), jaw fracture, temporomandibular joint dysfunction (TMJD), and numbness, tingling, or altered sensation in the teeth, lips, tongue, or surrounding tissues (paresthesia), which is typically temporary but may be permanent. I further understand that complications may arise during or after the procedure that could necessitate additional treatment by a specialist and, in rare cases, hospitalization, and that I am financially responsible for such treatment. The risks, benefits, and alternatives to extraction—including, but not limited to, root canal therapy, crowns, and periodontal surgery—have been explained to me. With this understanding, I voluntarily consent to and authorize Dr. Orffa Masso, DDS, to extract the following tooth/teeth:*

_____.

Patient or Responsible Party Initials: _____

☐ Crowns, Bridges, and Caps: *I understand that crowns, bridges, and caps (collectively referred to as "dental prostheses") are restorations designed to restore the function, appearance, and strength of my teeth. I acknowledge that the final color of the prosthesis may not perfectly match surrounding teeth and that temporary crowns or bridges may be placed prior to the permanent restoration, which can become loose or dislodge. I further understand that once a dental prosthesis is delivered, I am responsible for its care and maintenance, including repair or replacement if it is damaged, lost, or broken due to my actions. I consent to the placement of crowns, bridges, or caps as recommended by my dentist and understand the associated risks, benefits, and alternatives.*

Patient or Responsible Party Initials: _____

☐ Dentures (Complete or Partial): *I understand that dentures (full or partial removable dental prostheses) are designed to replace missing teeth and restore function and appearance. I acknowledge that dentures may cause temporary looseness, soreness, irritation, or sores in the mouth, and that breakage is possible if dropped or improperly handled. I understand that the final opportunity to make changes in shape, fit, size, placement, or color of the prosthesis is at the "try-in" visit, and that most dentures will require relining within 3 to 12 months after initial delivery to maintain proper fit. I further understand that the cost of any future relining or adjustments is not included in the initial denture fee, and that I am responsible for the care, maintenance, and safe handling of my dentures once delivered. I furthermore understand that wearing dentures can be difficult. Sore spots, altered speech, and difficulty eating are common problems. Immediate dentures (placement of dentures immediately after extraction(s)) may be painful. Immediate dentures may require considerable adjusting and several realignments. A permanent realignment will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return to the office for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitting dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. I consent to the fabrication and placement of dentures as recommended by my dentist and understand the associated risks, benefits, and alternatives.*

Patient or Responsible Party Initials: _____

☐ Endodontic Treatment (Root Canal Treatment): *I realize that there is no guarantee that root canal treatment will be successful, and that, in addition to the possibility of treatment failure, complications can occur such as: separation of instruments, swelling, sensitivity, bleeding, pain, infection, skin discoloration, changes in biting or TMJD, temporary or permanent changes in sensation of the lip, tongue, chin, gums, cheek, and teeth. Risks, benefits, and alternatives (ex. extraction of the tooth) have been explained to me by Dr. Masso and I authorize her to proceed with endodontic treatment of tooth #(s): _____.*

Patient or Responsible Party Initials: _____

☐ Periodontal Loss (Tissue & Bone): *I understand that I have been diagnosed with periodontal disease, which involves the loss of gum tissue and supporting bone around my teeth. I acknowledge that treatment provided in a general dental office—including scaling, root planing, and other nonsurgical therapies—can help control the disease but cannot fully restore lost tissue or bone. Referral to a periodontal specialist has been discussed as an alternative for more advanced care. I understand that surgical procedures such as gum surgery, gum/tissue grafting, or tooth extractions have been explained to me, including their risks, benefits, and alternatives. I further understand that any dental procedures, including routine care, restorations, or extractions, can potentially affect my periodontal condition, and that maintenance, good oral hygiene, and ongoing professional care are essential to manage disease progression. I consent to periodontal treatment as recommended by my dentist, understanding the potential limitations and risks*

Patient or Responsible Party Initials: _____

☐ Fillings: *I understand that special care must be taken when chewing on new fillings, particularly during the first twenty-four (24) hours, to reduce the risk of fracture or dislodgement. I acknowledge that additional decay may be discovered during treatment that was not visible on radiographs and could only be detected once Dr. Masso began removing the existing decay. In such cases, a more extensive—and therefore more costly—restoration than originally anticipated may be necessary. I further understand that temporary or significant sensitivity is a common and expected side effect following the placement of a new filling.*

Patient or Responsible Party Initials: _____

By initialing next to each treatment consent recommended by Dr. Orffa Masso, I acknowledge that the risks, benefits, and alternatives for each procedure have been explained to me. I further confirm that I have had the opportunity to ask questions about my treatment plan and that my questions have been answered to my satisfaction. By providing my initials and signing below, I voluntarily give informed consent for the selected treatments indicated and verify that I understand and agree to proceed with those procedures.

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____