Provident Dentistry - Novi
40105 Grand River Ave, Novi, MI 48375
(248) 471-0345
www.providentdentistry.com/

UPDATED PATIENT CONSENTS - 2023

| DOB:

Signature

Name of person filling out this form	
Relationship to patient	

Patient's signature: Date:

Doctor's signature: Date:

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UPDATED PATIENT CONSENTS - 2023

Patient Name:

Preferred Name:

Date of Birth:

In an emergency who should be notified? Please enter Name and Phone number below:	

By checking this box,

I authorize my insurance company to pay the dentist all insurance benefits rendered.

I authorize the use of this electronic signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient's signature: Date:

Doctor's signature: Date:

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PROVIDENT DENTISTRY POLICY

Provident Dentistry Policy

Our goal at Provident Dentistry is to provide caring, thorough, leading-edge dentistry. We pride ourselves in providing quality dental care meeting each patient's special diagnosed needs. All dental benefit contracts (dental insurance) differ widely and contain language that may limit your monetary reimbursement. Your dental needs should not be dictated by dental benefit limitations. If you have dental benefits our office will submit fees to your carrier for all services. It is your responsibility to give us the correct insurance company name, employee information, personal information and keep us updated of any changes. Incorrect or incomplete information can result in delays or non-payment of benefits.

- Any unpaid balance, whether it is a benefit payable by your insurance or not, is ultimately your responsibility.
- Unless arrangements are made, the patient portion of fees is due at the time services are rendered.
- Accounts that are not kept current monthly may be assessed a service charge.

Failed appointments and short notice cancellations are a loss to everyone. They have a direct impact on the cost of providing services. Failure to keep your reserved appointment or to give a 24 hour notice of a cancellation may incur a fee.

Thank you for your attention.

* By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature

for the AdministrationForm.

Patient's signature: Date:

Doctor's signature: Date:

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NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices

Please read this notice carefully, as it describes your rights regarding your health information and how it can be used and/or disclosed and how you can be given access to the information. The privacy of your healthcare information is important to us.

Legal Responsibility of Our Office:

Federal and state laws require us to provide you with this notice in regards to the protection of your private healthcare information. We are also required to give you this notice about our privacy policies and procedures, your rights in relation to your healthcare information and our legal responsibilities. This privacy policy take effect immediately (date) and will remain in place until our office replaces it. We must follow the privacy practices this notice sets forth.

It is the right of this office to change this policy at any time as long as the changes are in accordance with the applicable laws. Significant changes will result in the replacement of this Notice and the new Notice will be available upon request.

If you have any questions regarding our privacy policies or if you would like a copy of this notice, please contact our office using the contact information at the end of this Notice.

Healthcare Information Uses and Disclosures

Your healthcare information is used and disclosed for treatment, payment, and healthcare operations; for example:

Treatment: Our office may use or disclose your healthcare information to a physician or other healthcare provider who is providing treatment to you.

Payment: Your healthcare information will be used and disclosed by our office to obtain payment for services rendered to you.

Healthcare Operations: Our office will use and disclose your healthcare information in association with our healthcare operations. These operations include, but are not limited to: evaluation and review of healthcare professionals, quality reviews, assessments, improvement and training activities, licensing and credentialing activities, and certification and accreditation programs.

Your Authorization: In addition to the above uses of your healthcare information, you have the right to give us written authorization to use or disclose your private healthcare information to anyone for any reason. We will not

release your private healthcare information without your written authorization. You are allowed to revoke the authorization at any time; however, this revocation will not affect any prior uses or disclosures of this information that may have been released while this authorization was in effect.

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, 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, 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, post cards,

and/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. If you request copies, we will charge you a nominal fee for each page and 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 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 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 mean or locations 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 Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you need or want more information regarding our privacy practices or have any questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision our office has made regarding access to your healthcare information or a response we made to your request to amend or restrict the use and/or disclosure of your healthcare information or to have us communicate with you using an alternative means or location, you may have the right to complain to us using the contact information listed on the bottom of this Notice. You may also contact the Department of Health and Human Services in writing. We will be happy to provide you with the mailing information upon request.

Our office supports you right to the privacy of your healthcare information. We will not retaliate in any way if you deem it necessary to file a complaint with the U.S. Department of Health and Human Services.

* By checking this box, I acknowledge that I have ready this statement and agree to the contents.

Patient's signature: Date:

Doctor's signature: Date:

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PATIENT/RELATIVE HIPAA ACKNOWLEDGEMENT

PATIENT/RELATIVE HIPAA ACKNOWLEDGEMENT

Patient/Relative HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

*** By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Patient's signature: Date:

Doctor's signature: Date:

Please enter name and relationship to patient	

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CONSENT FOR TREATMENT

Consent for Treatment

Thank you for choosing Provident Dentistry for your dental care. We will work with you to help you achieve excellent oral health. In order to help formulate treatment recommendations, the following diagnostic procedures need to be performed:

Medical history, dental history, discussion of your dental concerns and desires, x-rays, intra oral photographs, examination of the mouth and associated structures, discussion with your previous dentist and/or health professional, if necessary. Benefits of dental treatment can include: relief of pain, ability to chew properly and the confidence and social interaction that a pleasing smile can bring about.

Drug or chemical reactions; dental materials that may trigger an allergic or sensitive reaction; long term numbness (parasthesia). The use of local anesthesia, or its administration can result in transient, or in rare instances, permanent numbness. Muscle or joint tenderness - opening of the jaw for a very long time can cause joint or muscle tenderness participating in TMJ disorder. Tenderness, sensitivity, bleeding or infection of the gum, especially after a cleaning, may occur. Swallowing or inhalation of small objects may occur.

Medical History: I do understand that I have answered all of the medical questions to the best of my knowledge and should there be need for further information, you have my permission to ask the respective health care provider.

Upon diagnosis of my medical needs, I authorize Provident Dentistry to perform the necessary treatment that was recommended to me.

Informed Consent: I certify that I have read and understand this informed consent, which outlines the general treatment considerations as well as the potential problems and complications of dental treatment. I understand that during and following treatment, future conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. I give permission to Provident Dentistry to contact me for the need of a dental appointment. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I verify that I have had full opportunity to read and consider the contents of this consent form. I understand that by signing this consent, I am giving my consent to use and discuss my protected health information to carry out treatment, payment activities and the risks of the recommended treatment.

*** By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Consent for Treatment Form.**

Patient's signature: Date:

Doctor's signature: Date:

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CONSENT FOR INTERNET COMMUNICATIONS

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

*** I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

Patient's signature: Date:

Doctor's signature: Date: