

## **Lakefront Dental General Consent**

We are pleased that you have chosen Lakefront Dental to be your oral health care provider. In order for us to provide optimal treatment, it is necessary for you to understand the types of treatment provided at Lakefront Dental, the fees for the treatment, and follow-up care. Please take a few moments to read this consent for treatment as it may clarify important questions and issues that may come up during treatment.

**GENERAL INFORMATION:** We see adults and children of all ages and offer preventive, pediatric, restorative and cosmetic dental procedures. Our goal is to stabilize and/or eliminate any oral disease process present in your mouth, and then to maintain your oral condition at a level of health and esthetics that is optimal for you.

**EMERGENCY DENTAL CARE:** Emergency dental treatment is intended to provide relief of pain and infection for individuals in acute need. Our emergency after-hours phone number is 312.505.2918, or you can email us at [lakefrontdental@gmail.com](mailto:lakefrontdental@gmail.com).

**CONSENT TO DENTAL PROCEDURES:** As a patient you will have access to current and complete information about your condition. Before receiving treatment you should ask your Lakefront Dental dentist about the procedure(s) recommended for you, and ask any questions you may have before you decide whether or not to give your consent for the procedure(s) to be done. All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result or cure. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. You have the right to consent to or to refuse any proposed procedure at any time prior to its performance.

**SCREENING AND DIAGNOSTIC TESTS:** Tests such as blood pressure, pulse and dental radiographic images will be made as necessary and appropriate for examinations, diagnosis, consultation and treatment.

**FINANCIAL RESPONSIBILITY:**

1. If you do not have dental insurance, you will be charged for treatment according to the fee schedule of Lakefront Dental at the time of treatment. A fee estimate will be provided prior to beginning treatment and you must be prepared to pay for services as they are performed.
2. If you have dental insurance for which we are out of network providers, you will be charged for treatment according to the fee schedule of Lakefront Dental at the time of treatment. A fee estimate will be provided prior to beginning treatment, and we will submit the charges to your insurance plan. All deductibles, copayments and non-covered services will be your financial responsibility. In addition, it will be your financial

responsibility to pay for any portion of charges submitted for services rendered that are not paid by your insurance.

3. If you have dental insurance for which we are in network providers, you will be charged for treatment according to the fee schedule of your insurance plan at the time of treatment. A fee estimate will be provided prior to beginning treatment, and we will submit the charges to your insurance plan. All deductibles, copayments and non-covered services will be your financial responsibility.

**DENTAL MEDICAL RECORDS:** The dental medical record, radiographic images, photographs, videos, models and other diagnostic aids relating to your treatment are the property of Lakefront Dental. You have the right to inspect such materials and to request a copy of your dental medical record and radiographic images. A fee of up to \$25.00 may be required for copying these items. You may also request to have your dental radiographic images sent to another health care provider by signing a Release of Information form. Lakefront Dental complies with requirements of the Health Insurance and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act. You will receive separate information, forms and consents in that regard. **In addition, your dental medical record may be used for instructional purposes and if it is, your identity will not be disclosed to individuals not involved in your care and treatment.**

**KEEPING YOUR APPOINTMENTS:** It is important for you to be on time for your appointments. If you find that you are unable to keep an appointment, you agree to notify Lakefront Dental at least 48 hours in advance.

I hereby acknowledge that a Lakefront Dental dentist has explained to me the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. I hereby acknowledge, agree and give my voluntary consent for treatment provided through Lakefront Dental as such treatment has been explained to me by my treating professional(s), their assistants and/or designees and as may be deemed necessary or desirable by my treating professional(s), their assistants and/or designees. This authorization includes, but is not limited to, routine diagnostic procedures, outpatient care, laboratory tests, x-rays, and other routine dental procedures. I understand that my treatment may include a variety of interventions. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at Lakefront Dental. I acknowledge that my care is under the direction of my treating professional(s) and I represent that I will follow the instructions of my professional(s) in the provision of said care.

Your signature of this form certifies that you have read and understand the information provided on the form, that you have received a copy, and that you accept dental care and treatment under the described terms and conditions.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_