

## Dental Treatment Consent / Medicaid Release / HIPPA/ Private Pay

Patient Name \_\_\_\_\_ Facility Name \_\_\_\_\_

### **1. Proposed Dental Treatment**

I understand that a licensed dentist has diagnosed a treatment plan with the estimate number \_\_\_\_\_ dated on: \_\_\_\_\_ . An estimated cost of \_\_\_\_\_ . Generalized description of that treatment plan include: \_\_\_\_\_ . As the responsible party, POA I have been given treatment options, risk, and cost of the above treatment and wish to proceed with the outlined treatment plan.

### **2. Drugs and Medications**

I understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction), which could in rare cases result in death.

### **3. Changes In Treatment**

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during the procedure. I give the dentist permission to make any/all changes necessary.

### **4. Removal of Teeth/ Oral Surgery**

Alternative treatment has been explained to me and I authorize the Dentist to perform the procedures necessary. I understand that risk involved in having teeth removed, and oral surgery, which can be pain, bleeding, sinus exposure swelling, spread of infection, dry socket, loss of feeling in lips, tongue and surrounding tissues that can last indefinite. Other risks include fractured jaw; osteonecrosis, bruising, hospitalization, death and further treatment may include or referral to a specialist.

### **5. Risk**

I understand that dentistry is not an exact science and therefore, dentist cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding treatment I have requested and authorized. I further understand that nursing home patients have greater risks and more compromised health, which result in greater risks. I have read this form and have opportunity to ask questions. I have been given treatment options and decided in good mind to proceed with the above recommendations. My questions have been addressed to my satisfaction and I as the responsible party/and or patient consent to the proposed treatment.

### **6. Dentures**

I understand that dentures are a man made replacement for permanent teeth. As people age the bony structures of the mouth sometimes resorb. As a result of the resorption of bone, dentures may not fit as tight as the patient may like. Using adhesives may be required in any given case. There are cases that the patient may decided the acrylic feels big and bulky as they may not be used to wearing a new appliances. Most of the time sore spots and adjustments can be made to end in a good result although there is a 20% chance that any denture may not be worn. Knowing this information, I would like to LifeCycle Dental Licensed Dentist fabricate dentures/partial to the best of their ability.

### **7. Fillings**

Fillings can become loose, fall out or may be swallowed. Placing a filling is not guaranteed to save the tooth indefinitely. The tooth may break and may need to need additional treatment and or an extraction.

### **8. Dental IME Payment Release and Specific Eligibility Information Release**

**I/We agree to designate payment to LifeCycle Dental Resource, Inc. for the above services as the funds become available through Medicaid Incurred Medical Expense program. I/We authorize the use and release of films and photographs for demonstration purposes, and hereby authorize the Nursing Facility and Health and Human Services to release the clinical records, Nursing Home Rent status Applied Income Amounts and Form 4808/1259, form 1263 to LifeCycle Dental Resource and hereby give HHSC permission to obtain any information that may affect my eligibility for assistance. As the Responsible Party(ies) I/We have read the above and agree to fulfill the requirements therein and allow LifeCycle Dental the authority to Represent the Client, for obtaining dental care and payment thru IME program. I understand that the improper designation of these funds for payment to LifeCycle Dental as they are released could be considered Medicaid Fraud and will be turned over for investigation, including the nursing facility, or responsible party.**

### **9. Private Pay Residents**

**Private Pay residents are responsible to pay half of the treatment plan before services are started and the balance at the completion of services. Payment arrangements may be made.**

### **10. HIPPA / Patient 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:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in treatment)
2. Obtaining payment from third party payers
3. 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 more complete 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 the notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.

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

**Patient/ Responsible Party Signature/POA** \_\_\_\_\_

**Today's Date** \_\_\_\_\_