CONSENT FOR TREATMENT

I hear by authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ____________________

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complication. I understand that I will be informed of any anesthetic, sedative or any other medication prior to dispensing.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health record that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available. I will be given the HIPAA forms to read and sign.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5 % late charge (18% APR) may be added to my account.

______________________________________ ____________ ______________________________

Patient / Parent / Guardian Signature (please circle) **Date** **Witness**

ASSIGNMENT OF INSURANCE BENEFITS

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless prohibited by law, or by treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with a claim.

____ _____________

Patient / Parent / Guardian Signature **Date**

I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

____ _____________

Policy Holder/Subscriber of Insurance **Date**

FINANCIAL OPTIONS

All treatment is to be paid at the time of service, unless insurance is involved and therefore your ESTIMATED CO-PAY is due at the time of service.

We offer as payment options: CASH, CHECK, MASTERCARD, VISA, DISCOVER

ASK US ABOUT OUR NO INTEREST PAYMENT PLANS THROUGH CARE CREDIT

KNOWLTON DENTAL ASSOCIATES
102 W. High Street
Elizabethtown, PA 17022
717-367-1560

HEALTH NOTICE: Studies show that sleep disordered breathing such as Snoring and Obstructive Sleep Apnea left untreated can have severe consequences on your health and possibly contribute to an early death. Studies show that these sleep disorders rival asthma and diabetes in scope across the population base. Some medical conditions such as Depression, Obesity, Impotence, Diabetes, Strokes, Congestive Heart Failure, Hypertension, Drug Resistant Hypertension, Coronary Artery Disease, Gastro Esophageal Reflux have been linked to sleep disordered breathing. The dental conditions of bruxing, clenching and grinding of teeth have also shown to be associated with sleep disordered breathing. Dentists have become partners with physicians to treat sleep disorders with a small mouth guard type of treatment. Dr. Knowlton has successfully treated patients over the last few years with these dental appliances. Please complete the below screening for our dental records and Dr. Knowlton will follow up with you if you are a candidate for dental oral appliance therapy to treat snoring and /or obstructive sleep apnea.

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1) Do you or a member of your family snore or have obstructive sleep apnea?

Yes_____ **No_____**

2) Have you or any member of your family had an overnight sleep test at a hospital or independent sleep center?

Yes_____ **No_____**

3) Are you or they currently being treated for snoring or sleep apnea?

Yes_____ **No_____**

4) How are you or they being treated?

CPAP_____ **Surgery_____**
Nasal Continuous Positive Airway Pressure

Dental Oral Appliance_____ **Other_____**

Comments:____

____

5) Are you or they in compliance...meaning still using the treatment?

Comments:____

____

Print Name:____________________ **Date:**__________ **Phone:**____________________