Patient Consent Form

Welcome to our practice, we are pleased that you have chosen us for your orthodontic needs. During this time, the patient may experience some discomfort due to the adjustments that will be made throughout orthodontic treatment. When there is discomfort, the patient may take Tylenol, Advil, or whatever is normally taken for a headache. Once treatment has completed, the patient will be issued retainers. Retainers must be worn as instructed, retainers are a lifelong process. If the patient loses his/her retainer, the patients insurance carrier may replace them one time only, provided it is within two (2) years after the orthodontic appliances are removed. This may be subject to age limits.

Privacy Practice
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 my 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 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 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 health 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 this restriction.

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Initials

Permission to Treat in Absence of Parent (if applicable)
I hereby give my permission to the office of Richard L. Byrd, DDS, PC permission to administer orthodontic treatment to my child in my absence.

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Initials

Permission to Discuss Protected Health Information
I hereby give my permission to the office of Richard L. Byrd, DDS, PC permission to discuss my/my child’s protected health information with the following individuals:

Name: ____________________ Relationship: __________ Phone: __________
Name: ____________________ Relationship: __________ Phone: __________
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Orthodontic Treatment
To keep your treatment on track, please make every effort to keep every appointment. If you need to cancel or reschedule your appointment, we require a twenty-four (24) hour notice. Missed appointments may cause delays in treatment and may be subject to a $25.00 missed appointment fee. If you need to cancel or reschedule an appointment, please call our office at (804) 330-0508. We ask that during treatment, that you adhere to the following rules and regulations. Failure to comply may result in your orthodontic treatment being discontinued.

1. The patient must have a family dentist. This is not Dr. Byrd or Dr. Smith, as they are your orthodontists.
2. The patient must have regular dental check-ups and cleanings every six (6) months.
3. All orthodontic recommendations are followed as instructed.
4. No breakage.
5. Must keep orthodontic appliances clean.
6. Must not miss appointments.
7. Must brush and floss three (3) times a day.

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Initials

Non-Compliant Dismissal
If the patient becomes non-compliant, we reserve the right to remove any and all orthodontic appliances. We will issue three (3) warnings and discuss with the patient the problem that we are having keeping the patient on track with his/her treatment. If we are unable to correct the problem, we will have no other recourse but to discontinue treatment and remove all orthodontic appliances. Once the treatment has been discontinued due to non-compliance, your insurance carrier (if applicable) will be notified as to the decision of this office. The reasons for dismissal as a patient are as follows:

1. Recommended treatment is not carried out or there is a lack of cooperation on the part of the patient/parent.
2. Repeated breakage and careless handling of the appliances.
3. Failure to keep teeth and appliances clean
4. Repeated missed appointments that are not cancelled within twenty-four (24) hours advance time period.
5. Not following the rules and regulations set forth by this office. Example: foul language, abusive behavior towards the doctor and staff, refusing not to use your cell phone while in our office, refusing to update patient/parent information.
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I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of ____________________, 20____.

Print Patient Name

Signature of Responsible Party

Relationship to Patient

Address

City, State, Zip

Home Phone ____________________________ Work Phone ____________________________

Cell Phone ____________________________ Email Address ____________________________

☐ Are you requesting a copy of our Notice of Privacy Practices?

☐ Patient/Client Refuses to Acknowledge Receipt:

____________________________________________  __________________________
Signature of Staff Member                     Date

Patient Name: ________________________________

Responsible Party Name: __________________________

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