Smile Partners

Debra Olsen, RDHAP
Registered Dental Hygienist in Alternative Practice
California License: HAP #187

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CONSENT FOR TREATMENT

Patient Information

Name: _____ Sex: _____

Home Address: _____ City, State, Zip: _____

Medi-Cal ID # _____ Date of Birth: _____

Special Care Facility Information / Address

Name of Facility _____ Phone: _____

Facility Address: _____ City & Zip: _____

Facility Contact Name: _____Title: _____

Physician Information

Name: _____ Phone: _____ Fax: _____

Address: _____City, State: _____ Zip _____

Describe any current or long-term disability/medical condition:
Please circle Yes or No:

Heart Murmur	Yes	No	High Blood Pressure	Yes	No	Radiation Therapy	Yes	No
Heart Pacemaker	Yes	No	Mitral Valve Prolapse	Yes	No	Cerebral Palsy	Yes	No
Heart Attack	Yes	No	**Hip/Joint Replacement ****	**Yes**	**No**	Multiple Sclerosis	Yes	No
Diabetes	Yes	No	Hepatitis	Yes	No	Blindness	Yes	No
Stroke	Yes	No	Epilepsy / Seizure Disorder	Yes	No	Deaf	Yes	No
HIV	Yes	No	Dementia	Yes	No	Parkinson's Disease	Yes	No
Dialysis	Yes	No	Alzheimer's Disease	Yes	No	Hemophilia	Yes	No

If Yes to Hip/Joint replacement, an antibiotic **MAY** be required 1 hr prior to the appointment. Please have the MD prescribe the appropriate antibiotic and have ready on the day of treatment. Take the antibiotic 1 hour prior to the scheduled appointment.

Any other medical conditions not listed:_____

Specify any allergies: _____

List any medications: _____

_____

_____

Medi-Cal/ Dental, Share-of-Cost and or Patient Trust accounts may be billed for Dental Hygiene Treatment. Medi-Cal will be accepted as full payment if eligible at the time of service. Smile Partners will also bill Delta Dental Insurance as a courtesy. No other dental insurance companies will be billed. Instead, a Super-Bill will be provided and marked PAID for your own billing purposes. Permission is authorized for third-party (insurance) payment directly to Smile Partners. All fees are ultimately the responsibility of the Responsible Party. All fees are due 30 days from date of invoice. **After 30 days, a $10 per month Billing/Late Fee will be assessed.**

NOTIFICATION TO CONSUMERS DENTAL HYGIENISTS ARE LICENSED AND REGULATED BY THE DENTAL HYGIENE COMMITTEE OF CALIFORNIA
(916) 263-1978 WWW.DHCC.CA.GOV

Please complete backside– Page 2. Thank you.

Type of Billing: (please check) ___ Private Funds ___ Medi-Cal ID No. _____
___ Delta Dental Insurance

Please attach a copy of current Medi-Cal Benefits Identification Card. Medi-Cal Card Issue Date: _____

Patient Name: _____ Facility Name: _____

For Delta Dental: Is this a PPO plan _____ Is this an HMO Plan _____ If patient is not allowed to see the provider of choice, this plan may not cover these services. Please speak with the Human Resources Department to assign Debra Olsen, RDHAP as the provider of choice prior to accepting services.

Group Name: _____ Group Number: _____

Send Claims to (address): _____

_____

Name of Insured: _____ Relationship to Patient: _____

SSN of Insured: _____ Birthdate of Insured: _____

Dental Insurance Phone Number (for eligibility and claim information): _____

All information regarding dental insurance is necessary. If information is not complete, treatment may be delayed or you may be billed directly.

In accordance with current Privacy Regulations created by the Health Insurance Portability and Accountability Act, (HIPAA), we are required to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information that describes how we may use and disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that are permitted or required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your dental health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your care.

We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior to approval or to determine whether your plan will cover treatment.

Name of Responsible Party: _____ Phone: _____

Mailing/Billing Address: _____ Fax: _____

City, State, Zip: _____ Relationship to Patient: _____

Cell Phone _____ Email Address _____

Permission granted for review of medical records.
An Associate RDHAP may be the provider of dental hygiene services.
Permission granted to take pictures of patient for chart identification / insurance billing purposes and or educational purposes.

All fees are ultimately the responsibility of the " Financial Responsible Party".

_____ Date: _____
Signature of Responsible Party/ POA for Healthcare

_____ Date _____
Signature of the Financial Responsible Party