COMMUNITY DENTAL HEALTH
1436 N. Hancock Avenue
Colorado Springs, CO 80903
(719) 310-3315

_____ In the care of _____

Print Patient Name/Resident Legal Guardian/Power of Attorney

CONSENT TO TREAT

Hereby voluntarily consent to the rendering of dental exams, x-rays, fillings, extractions, hygiene service, including cleaning of teeth, oral screening, fluoride application and professional referrals by authorized members of Community Dental Health staff or their designees, as may in their professional judgement is necessary to help preserve the oral health of said patient. Depending upon medications, health of mouth and individual, amount of buildup, possible post op conditions may include and are not limited to soreness, bleeding tissue, swelling, bacteremia, sensitivity and awareness of loose teeth.

_____ **INITIAL**

CANCELLATION POLICY

Due to high cancellation rates and in order to ensure the life of this program for the many people who need it, the following policy will be enforced for all patients. Each patient is allowed two cancellations, with less than 48 business hours' notice. Upon a patient's second cancellation, they will be given a date to come to the assigned clinic when we open and wait to be seen (if we can work you in, based on the schedule for that day) for their next appointment. Repeated cancellation will result in a patient's dismissal from the program. Changes to the cancellation policy are at the sole discretion of the Director of Community Dental Health.

_____ **INITIAL**

PRIVACY POLICY

Community Dental Health (CDH) will treat all patient information as Protected Health Information (PHI) under HIPPA regulations, as, exchanging PHI only with personnel employed by SMD, Power of Attorney, healthcare providers, for this patient and the patient's nursing home who is responsible for medical treatment, record review and billing, where applicable. Other desired releases of PHI may be specified on the HIPPA Authorization Form. Initialing here indicated review of full privacy policy (posted next to check in).

_____ **INITIAL**

FINANCIAL POLICY

We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close estimate of your next visits total bill. Please bring cash or check at the time of treatment. **PAYMENT IS DUE AT THE TIME OF SERVICE**.

We accept credit/debit cards but there is an $8 per $100 service fee. Being a non-profit organization, we cannot absorb these fees. You can avoid these service fees by paying with cash or check.

A returned check fee of $25.00 (subject to change as bank fees increase) will be added to your account for any returned checks. Before we schedule another appointment or accept another payment by check, the $25.00 fee plus full payment for the check that did not clear must be paid in cash.

_____ **INITIAL**

I have read and understand the above information_____

Patient/Guardian Signature Date