DENTAL
COMMUNITY
HEALTH
MEDICAL • DENTAL • BEHAVIORAL HEALTH

RUTLAND | 69 Allen St., Suites 7 & 10, Rutland, VT 05701 | 802-774-5050
SHORWELL | 2987 VT Route 22A, Shoreham, VT 05770 | 802-897-7716

CHCRR.org

DENTAL CONSENT

For Treatment, Release of Information and Assignment of Insurance Benefits

A. I authorize and give my consent to Community Health Dental offices, their agents, employees, and to all medical personnel, including but not limited to dentists, hygienists, technicians and healthcare staff at Community Health (all of the aforementioned herein collectively referred to as "Community Health Dental Providers") and agree to a radiographic and clinical examination. I authorize and give my consent to Community Health Dental Providers to provide procedures which are recommended for optimal oral health. I also understand and consent to the following: during the course of treatment, that I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography. I authorize the sharing of my medical information with Community Health Teams that have been established to help assess my needs, coordinate community based support services, and provide multidisciplinary care. I acknowledge that no representations, assurances or guarantees have been made to me regarding the effects or results of any treatment outcomes, restoration longevity, or prognosis rendered to me.

B. I consent to the disclosure of my prescription medication information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health benefits program, to Community Health Dental Providers for the purpose of my treatment. My consent includes the redisclosure of prescription medication information received from a drug or alcohol treatment program.

C. I authorize Community Health to disclose my protected health information, including the diagnosis and copies of records of any treatment or examination rendered to me or my dependent during the period of such case, to third party/payers and/or other health practitioners. I authorize my insurance company to make all payments for covered services directly to Community Health and Community Health Dental Providers for the services billed by them and hereby assign my rights to such insurance company payments to them. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or my dependents, in accordance with my health care plan that Community Health is entitled to collect. I understand that all of my bills will be sent to the responsible party who is named on my account.

D. For the purpose of advancing medical and dental education, I authorize the attendance of healthcare students participating in Community Health programs.

E. I authorize Community Health Dental Providers to appropriately dispose of any specimens/tissue specimen taken from my body, or, as applicable, sent to pathology for evaluation in agreement with my designated dental provider. Once disposed of, these specimens/tissue cannot be retrieved.

F. I authorize and give consent to Community Health Dental Providers involved in my care, to access, use and disclose among themselves and to others my Protected Health Information for my care and treatment and disclose it to my insurance carriers and others for payment for my care and treatment.

G. I authorize Community Health Dental Providers to electronically forward or call in my medication prescriptions to the pharmacy I designate.

H. If I have a work related incident/injury, I authorize Community Health to release information to my employer as deemed necessary for payment of services rendered.

I. I agree that in order for Community Health Dental Providers to service my account or to collect any amounts owed to them that they, or their agents, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me and by sending text messages, or e-mails, using any e-mail address provided to them. Methods of contact may including using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

J. I consent to treatment at any Community Health Dental office. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended I understand that I have the right at any time to discontinue services with Community Health.

K. This consent is subject to my written revocation at any time except to the extent it has already been acted on.

L. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consents.

M. I understand and agree that Community Health may at its discretion provide certain services to me by remote means called "teledentistry". Such teledentistry services improves access to dental care and involves a dentist who is at a site remote from my location at the time of service. teledentistry may involve the secure transmission of video, audio, images, pictures and other types of information in real time or via a store and forward application. The remote provider will determine whether the condition being diagnosed or treated is appropriate for teledentistry I understand that I will be informed of the presence of any other individual who will be participating in or observing my consultation.

N. FOR MINORS:
I (parent or guardian or Loco Parentis) authorize Community Health Dental Providers to provide the necessary care and treatment, including but not limited to prophylaxis, fluoride, x-rays and sealants.

Print Name of Patient	Patient Date of Birth
Signature of Patient, or if minor, as applicable, Parent/Guardian/Loco Parentis	Date

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have been offered Community Health's Notice of Privacy Practices dated September 22, 2022. I acknowledge and agree to the terms of Community Health's Notice of Privacy Practices. I understand that if I have questions, I should contact the Community Health Corporate Compliance & Patient Relations Manager, 71 Allen Street, Suite 101, Rutland, VT 05701, 802-855-2097, patientrelations@chcrr.org.

Print Name of Patient	Patient Date of Birth
Signature of Patient, or if minor, as applicable, Parent/Guardian/Loco Parentis	Date