MOBERI
DENTAL SPECIALISTS
UNPARALLELED COMMITMENT | UNCOMPROMISED CARE

Privacy Consent

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- ✓ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ✓ Obtain payment from third-party payers.
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right of review such NOTICE OF PRIVACY PRACTICES prior to signing this consent.

I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature of Patient or Guardian:

_____ Date: _____

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ENDODONTIC HEALTH HISTORY FORM

Name: _____

YES	NO	
__	__	Are you presently in pain?
__	__	Are you taking blood thinners?
__	__	Are you taking medications?

If yes please list in the box below.

Have you ever had a reaction to the Following:

YES	NO		
__	__	Pain meds.	
__	__	Latex	
__	__	Penicillin	
__	__	Local anesthetic	
__	__	Antibiotics	
__	__	Other	

Have you ever had the following:

YES	NO		YES	NO	
__	__	Cancer therapy	__	__	Heart Trouble
__	__	Tuberculosis	__	__	Rheumatic Fever
__	__	Kidney Trouble	__	__	Phen/Fen
__	__	Liver Trouble	__	__	TMJ Disorder
__	__	Diabetes	__	__	Artificial Joints
__	__	Allergies	__	__	HIV, AIDS
__	__	High Blood pressure	__	__	Hepatitis **A B C** (choose one)
__	__	Herpes			

Is there any other information about your health that we should know?

DO YOU REQUIRE PREMEDICATION WITH ANTIBIOTICS FOR ANY OF THE FOLLOWING REASONS:
(CHECK ALL THAT APPLY)

__ Artificial Joints

__ Heart Condition(s)

__ Rheumatic Fever

Pharmacy #. _____

(Please provide a number **NOT** a location)

List of Medications:

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ENDODONTIC HEALTH HISTORY FORM

TO ASSIST US IN UNDERSTANDING AND DIAGNOSING YOUR DENTAL CONDITION, PLEASE ANSWER THE FOLLOWINGQUESTIONS TO THE BEST OF YOUR ABILITY

Please list ALL your operations, surgeries, and hospitalization ***with any complications*** **(DO NOT LIST IF YOU DID NOT HAVE ANY COMPLICATIONS):**

Are you now under a physician's care, or have you been during the past five years, including hospitalization and surgery?

Have you taken Cortisone or other steroids in the past 24 months? ☐Yes ☐No

For what condition: _____

Have you had ophthalmic (eye) surgery in the past 8 weeks? ☐Yes ☐No

Have you or your family had an adverse reaction to any dent or general anesthetic? ☐Yes ☐No

What type of reaction: _____

Have you had any adverse effects to dental treatment? ☐Yes ☐No

When you walk upstairs to take a walk, do you ever have to stop because of pain chest, shortness of breath, or because you are very tired? ☐Yes ☐No

Are you in good health? ☐Yes ☐No

Has there been ANY change in your general health in the past year? ☐Yes ☐No

Date of last physical exam:

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ENDODONTIC HEALTH HISTORY FORM

WOMEN:

Are you pregnant? ☐Yes ☐No

How far along: _____

If yes, are you currently nursing? ☐Yes ☐No

If no, could you be pregnant or do you anticipate becoming pregnant in the upcoming year? ☐Yes ☐No

Are you using birth control pills, patches, or shots? ☐Yes ☐No

Disclaimer: If you are using birth control pills it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please consult with your physician for assistance regarding additional methods of birth control.

Disclaimer: If you are pregnant, or POSSIBLY pregnant or trying to become pregnant, surgery, anesthetics or any other medications may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any change of your being pregnant.

FOR ALL PATIENTS MALE AND FEMALE:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal tests, or if my medicines change, I will inform the doctor at the next appointment without fail. I have had a chance to ask questions. I understand x-rays and local anesthetics may be required for treatment.

I also state that I read and write English or this information has been translated to me in my primary language.

SIGNATURE OF PATIENT OR GUARDIAN: _____

DATE: _____

INFORMED CONSENT FOR ENDODONTIC TREATMENT

The Medical Consent Law requires doctors to advice patients of the general nature of the treatment procedures, the acceptable treatment alternatives, and the risks inherent in the proposed procedures.

I voluntary consent to endodontic (root canal) treatment that has been recommended. I understand that the goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate it is a dental-biological procedure, whose results cannot be guaranteed. Further, root canal treatment is performed to correct an apparent problem; and occasionally undiagnosed or hidden problems arise. I understand that this procedure will not prevent future tooth decay or possible fracture, and that occasionally a tooth that had a root canal treatment may require re-treatment, surgery, or tooth extraction.

The treatment has been fully explained to me including the risks involved. I have been informed that complications might include, but are not limited to:

a) Perforation of the canal with instruments, which could result in the need for root canal surgery or the loss of the tooth.
b) Instrument breakage in the canal, which may require re-treatment, root canal surgery, or extraction.
c) Incomplete healing, which may require re-treatment and/or root canal surgery or extraction.
d) Post-operative infection, which may require additional treatment or tooth extraction.
e) Referral to a specialist if any unexpected difficulties occur during the treatment.
f) Post-treatment discomfort altered feeling of the soft tissues of the mouth.
g) If the tooth has a crown, crown breakage or dislodged might occur, and crown replacement might be recommended.

I am aware that the condition of the tooth will worsen and that other systemic (medical) problems could possibly develop if the recommended procedure is not done. It has been explained that other treatment options might be possible, such as, tooth extraction, and followed by fixed or removable bridge-work, or placement of dental implants.

After the completion of the root canal procedure, you will be referred back to your restorative dentist for the permanent restoration (filling, crown, onlay). Failure to have the tooth properly restored significantly increases the possibility of re-infection, failure of the root canal procedure, and/or tooth fracture.
I had an opportunity to ask questions of my doctor and am fully satisfied with the answers that I have received.

Patient/Guardian _____ Date:_____

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Financial, Insurance Agreement and Patient Billing Policies

Financial Options

We would like to provide you with information about our office financial policy before your visit. Unlike your general dentist, as a specialty practice, we may only see you as our patient for one treatment visit. Therefore, **payment is due at the time services are rendered**. As a courtesy, if you have dental insurance we will bill your carrier, provide documentation, claim forms, radiographs, and treatment narratives. We will request that you pay your estimated co-payment at the time of service. We accept cash, checks, Visa, MasterCard, Discover and American Express. We also offer financing and payment plans, which can be, arranged in advance, prior to your appointment. Our preferred payment plan, Care Credit, is hassle-free and extends payments to fit comfortably within your budget. Please ask us if extending payment is important for you.

Insurance

The main thing to understand about your insurance coverage is that it is a contract between you, your employer and the insurance company. We will verify your coverage and give you an **estimate** of what your out of pocket expense should be. Your estimated co-payment is due at the time services are rendered.

For In-network insurance patients; your plan will have eligible benefits for most services provided. **We have no control over what your plan covers or how much it pays for any procedure. The cost of any uncovered procedure will be your responsibility.**

For those patients whose plans that are Out-of Network, we request 50%payment for our professional services at time treatment is rendered.

We strive to help you maximize your benefits, and can expedite the reimbursement process by electronically filing your claim on your behalf as a courtesy to you. You also have the option of paying for your treatment in full at the time services are rendered and filing your claim on your own for direct reimbursement. In any event, entire payment is expected to be paid in full within 6 weeks of treatment rendered.

Billing

In order to ensure the remaining percent of the fee is received, a credit card pre-authorization form will be completed, granting James C. Morrison Jr., D.M.D permission to charge the remaining balance or credit to your credit card. Most insurance companies will respond within 30 days. We will send you a statement if necessary. Please contact our office at 281-855-3380 if your statement does not reflect your insurance compensation within that time frame. Any remaining balance after your insurance has paid is your responsibility. Your prompt remittance is appreciated.

By signing this document verifies that I have read and understand its purpose contents.

_____ _____

Signature of Patient or Guardian Date

As a courtesy, Greater Houston Endodontics will gladly file your dental insurance. However, in some circumstances, we may overestimate the insurance payment, which will result in an open balance. To prevent any overdue balances and additional finance charges to your account, in compliance with our credit card provider, we will store your credit card information within our secure credit card terminal supplied through JetPay. The information provided on this form will be immediately destroyed once it has been transferred into our JetPay terminal.

I, _____, authorize James C. Morrison, Jr., DMD to charge the amount due 60 days from the initial date of treatment or once we have received payment/explanation of benefits from your insurance company. However, I agree that my verbal consent must be given prior to the processing of the credit card on that particular day. I certify that the information on this form is correct and true, and will notify James C. Morrison Jr., DMD immediately of any changes.

Circle card type: ☐**AMEX** ☐**DISCOVER** ☐**MC** ☐**VISA** ☐**DEBIT** ☐**CARE CREDIT**

Card # _____

Credit card Exp. Date: _____

Card Holder Name: _____

Card Holder Signature: _____

Card Holders Address: _____
(If different from patient address)

City: _____ **ST** _____ **Zip** _____

Email: _____

(REQUIRED FOR ALL INSURANCE PATIENTS)

This application shall apply indefinitely unless revoked by the cardholder in writing. James C. Morrison, Jr. DMD reserves the right to discontinue such payment method at any time. James C Morrison, Jr. DMD reserves the right to charge a service fee for any Rejected or NSF transactions.

WE DON'T ACCEPT CHECKS