NOVERA
ORAL HEALTH STUDIO

Authorization

I have completed the above information to the best of my knowledge. I understand that it is my responsibility to inform the doctor if there have been any changes in my health and or my child's health. All care will be explained prior to treatment and will only be performed after I consent to such treatment. I authorize the doctor and any other employed staff (under doctor supervision and within the confines of the law) to perform any necessary treatments in regards to providing proper dental care.

Patient (or patient's parent or guardian) _____ Date:_____

You are fully responsible for payment of all dental services. If you have dental insurance, we will do our best to explain to you what is covered by your insurance and what you are responsible for. You are responsible for any deductible amounts or portions that your insurance does not cover. Our treatment plans are simply an estimate of what your insurance may cover. You are responsible for any portions of services not honored by your insurance company. You may be contacted in the future by our staff in regards to future appointments and for promotional purposes. Your information may be turned over to a third party collection agency in relation to collecting payment. By signing below you acknowledge that you have thoroughly read this document and that you understand it completely and accept its terms.

Patient (or patient's parent or guardian) _____ Date: _____

We request 48 hours' notice to reschedule or cancel any appointment. This will allow us time to offer the newly available appointment slot to other patients. While we understand that unforeseen circumstances occur, we just ask that you please respect the time that we have reserved just for you. An assessed fee of $75 will be charged to your account for late notice and/or no shows.

An appointment in our schedule is a bond of trust that we will be here to serve you and you will be present for treatment. Our office policy is firm in this regard and we will not tolerate frequent cancellations or constant short-notice changes. We must have mutual respect for each other's time. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. If two broken/missed appointments or two cancellations occur without 48-hour notice, our office reserves the right to NOT schedule any subsequent appointments. Also, if you arrive 15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.

Patient (or patient's parent or guardian) _____ Date: _____

I hereby give Novera, and any and all employees and/or agents of Novera, the right and permission to use and/or publish photographs of me and/or testimonials for art and promotional purposes (including but not limited to, advertising, publicity, commercial or display of use). I hereby release and discharge Novera and all persons functioning under his/her permissions or authority from any legal or equitable claims including but not limited to the following: blurring of the image(s), alteration, distortion or use in composite form, libel, invasion of privacy or any claims based on the production or in the process of recording or publishing the materials.

Patient (or patient's parent or guardian) _____ Date: _____

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INITIAL CONSENT AND PRIVACY POLICY

Initial Consent

Treatment Consent
I understand that I may have any or all of the following procedures done today or at a following appointment (as needed): exam, xrays (radiographs), cleaning (prophylaxis), fluoride treatment, local anesthetic, and fillings.

Allergies
I understand that antibiotics, pain medications, latex, and other substances may cause allergic reactions which may cause serious medical conditions. I have informed the dentist and staff of any allergies or medical conditions that I have, including pregnancy.

Changes to Treatment
I understand that changes to planned treatment may be needed during treatment due to conditions not foreseen during the exam and treatment planning phase of care.

Financial Obligation
Ideal treatment is determined by the dentist at the time of exam and will be presented to the patient. I understand that treatment plan breakdowns are only estimates of what the insurance will pay. I understand that I am obligated to pay any fees associated with treatment as well as any portion, if any, not paid by the insurance company.

Privacy Policy

This notice describes how HEALTH information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This Notice describes the privacy practices of Novera Oral Health Studio ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

Our Use and Disclose of Your Health Information Without Your Written Authorization

Treatment: We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment: We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations: We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders: We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, or email.

Treatment Alternatives and Health-Related Benefits and Services: We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends: We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Disclosures Required by Law: We may use or disclose your health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

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Public Health Activities: We may disclose your health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities: We may disclose your health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions: We may disclose your health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes: We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors: We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Organ, Eye and Tissue Donation: We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes: We may use or disclose your health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety: We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Specialized Government Functions: We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation: We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information: We will make other uses and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

BY MY SIGNATURE, I CERTIFY THAT I HAVE RECEIVED AND READ A PRINTED COPY AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION. I AGREE AND CONSENT TO THE ABOVE MENTIONED STATEMENTS.

Date:	
Patient Name:	
Patient Signature:	Click here to sign.