Schroeder Dental

General Consent Form

Erin L. Schroeder, DMD
4781 Paoli Pike, Suite 3
Floyds Knobs, IN 47119

Patient Full Name:_____ Date of Birth: _____
(Print name)

Payment: I understand that payment is required at the time of service. If I/the patient have/has dental insurance coverage, I authorize Dr. Schroeder & her staff to submit claims and any necessary information on my behalf directly to my dental insurance company(ies) for services provided. I understand that I am financially responsible to the provider for the charges not paid or payable. I understand that my/the patient's dental insurance contract(s) is/are between myself/the patient and the dental insurance company(ies) and certain procedures may not be covered by my plan. It is my/the patient's responsibility to know and understand the benefits of my dental insurance policies. Schroeder Dental/Dr. Schroeder is not responsible for knowledge of my policy coverage, claims are submitted as a courtesy to patients. Any copays will be due at time of service. A deductible and maximum may be applicable on my policy. By initialing to the right and signing below I agree to the above stated information.

Patient Initials _____

Consent for Diagnostics & Treatment: I consent for Dr. Schroeder and/or a qualified assignee to administer treatments and/or diagnostic tests to my/the patient's dental disease/issue/injury. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receive(s). I consent for Dr. Schroeder and her staff to discuss any medical conditions/medications with my doctor for my health, well-being and safety during dental treatment. By initialing to the right and signing below I agree to the above stated information.

Patient Initials _____

Phone Numbers & Emails: As a service to our patients, we provide courtesy appointment reminder calls/e-mails/text messages and possibly other important calls/e-mails/text messages that may be placed by a staff member or a prerecorded message. By providing your cellular, wireless, landline, home and/or work phone number/e-mail address, you consent to receiving such calls/e-mails/text messages at this number/e-mail address. By initialing to the right and signing below I agree to the above stated information and understand that data fees may apply.

Patient Initials _____

Notice of Privacy Practices:
I acknowledge receipt of the Notice of Privacy Practices. Patient Initials_____ Declined_____

Patient Photograph: I consent for Schroeder Dental to photograph me/the patient for identification and/or diagnostic purposes only. Patient Initials_____ Declined_____

Involvement of Others in Care: I authorize Dr. Schroeder and Schroeder Dental Staff Members to provide and discuss my/the patient's care and medical needs/information with the following persons:

NAME	DATE OF BIRTH	RELATIONSHIP	PHONE

By signing below I agree that I understand and consent to the above information and have been given the opportunity to ask questions and have those questions answered

X _____ _____
Patient/Parent/Legal Guardian/Legal Authorized Representative Signature Date

If Parent/Legal Guardian/Legal Authorized Representative
Print Name: _____

Office Use Only:
Written acknowledgement of receipt of Notice of Privacy Practices was not obtained because of:

- ☐ Individual's refusal to sign
- ☐ Communication barrier
- ☐ An emergency situation
- ☐ Other (Please Specify)