Bethesda Family Smiles
10401 Old Georgetown Rd. #310
Bethesda, MD 20814
(301) 530-0700
Fax: (240) 223-0384

Patient's Name_____
Patient's DOB_____

Consent for Email/Text Messaging Communications

Patients in our practice may be contacted via email and/or text messaging to provide patient/health related reminders/information, to remind you of an appointment, and/or to obtain feedback on your experience with our team.

☐ I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to.
The cell phone number that I authorize to receive text messages is (_____) _____ - _____

☐ I consent to receive emails from the practice at my email address and any email address forwarded or transferred to.
The email that I authorize to receive email messages is_____.

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information. If you would like to stop receiving text messages/emails, please inform a Bethesda Family Smiles staff member.

Sign: _____ Date: _____
Patient Signature (Parent/Guardian if patient is minor)

Consent for Dental Treatment and Financial Responsibility

I voluntarily consent to receiving dental treatment at Bethesda Family Smiles. I understand that if I have dental insurance, it will be filed on my behalf. I also understand that I am financially responsible for the treatment(s) done regardless of insurance payment or nonpayment. If you have any questions about your insurance, please consult your employer or your insurance company directly. I understand that each individual insurance plan is a specific agreement between the plan purchaser (usually the employer) and the insurance company. As such, each plan will vary on what they will cover for each insured party, including any exclusions or frequency limitations. For any patient who misses or cancels their scheduled appointment with less than 48 hours' notice in any 12 month period there will be a **$50.00** charge for each appointment. For more than 3 missed or cancelled appointments with less than 48 hours' notice, you may not be considered for future dental care at this office. There will be a **$35.00** charge for all returned or insufficient fund checks. Prior to accepting treatment, Bethesda Family Smiles will have resolved any questions and concerns about the above treatment to my satisfaction.

Sign: _____ Date: _____
Patient Signature (Parent/Guardian if patient is minor)

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Sign: _____ Date: _____
Patient Signature (Parent/Guardian if patient is minor)

To view complete details regarding any topic listed above, please see a team member