Welcome to Cornerstone Dental

Thank you for choosing us to be part of your healthcare team. We are very happy to have you join our practice and we appreciate the confidence you have placed in us to care for your oral health care needs.

Our primary goal is the preservation of your oral health. Optimal oral health is a lifetime commitment and we are devoted to helping you ***“Love Your Smile!”***. Our desire is to foster relationships that are based on mutual trust and understanding, open communication, and excellent customer service.

Our Pledge:

We at Cornerstone Dental, through continued medical and dental education, are devoted to your oral health. We will do everything possible to provide you with the best treatment, the most up-to-date practice philosophies, and the most current oral health information in a fun and pleasant environment...so that we may help you ***“Love Your Smile!”***

We are a full-service dental practice offering a comprehensive range of dental services to meet your individual needs, schedule, and budget. No individual is the same and your treatment plan will be carefully designed and tailored specifically to you. We strive to assist you in achieving your oral health care goals by using the most current information and up-to-date practice philosophies. We focus on creating a comfortable family atmosphere while providing gentle and efficient care.

We understand that financial concerns may exist for many patients. We believe that financial hardship should never stand in the way of health care. Open communication can benefit both parties, so please discuss your circumstances with any of our Patient Care Coordinators so that payment arrangements can be made as early as possible.

Again, welcome to our practice and thank you for choosing Cornerstone Dental for all your oral health care needs! Please visit our website at [www.cornerstonedentalny.com](http://www.cornerstonedentalny.com) to learn more about our practice, the doctors, and our office hours.

**General Office Information**

Locations: Cornerstone Dental, LLP Cornerstone Dental of Henrietta, PLLC

3770 Mt. Read Blvd. 2104 E. Henrietta Rd.

Rochester, NY 14616 Rochester, NY 14623

Phone: (585) 865-7030 Phone: (585) 334-8350

Fax: (585) 865-1425 Fax: (585) 334-0390

Hours of

Operation: M, T: 7:30am – 6:30pm M-Th: 8:00am – 5:00pm

W: 7:30am – 5:30pm F: Closed

Th: 7:30am – 4:30pm

F: 7:30am – 1:30pm

Email: [info@cornerstonedentalny.com](mailto:info@cornerstonedentalny.com)

Website: [www.cornerstonedentalny.com](http://www.cornerstonedentalny.com)

FaceBook: [www.facebook.com/cornerstonedentalny](http://www.facebook.com/cornerstonedentalny)

Instagram: cornerstonedentalny

Practice Administrator: Stacy Demchock

**Services**

**Diagnostic Services:**

Comprehensive Exams

Radiographs(including 3-D imaging)

Digital Scans

Intra-oral Photographs

Oral Cancer Screening

**Preventive Care:**

Prophylaxis (dental cleaning)

Periodic Exams

Cavity Detecting X-Rays

**Periodontal Services:**

Gingivitis Therapy

Periodontal Therapy

Scaling & Root Planing (deep cleaning)

Gingival & Bone Grafting

Corrective Therapy for “Gummy Smile”

Corrective Therapy for Gingival Recession

**Orthodontic Services:**

Clear and Metal Braces

Clear Aligners

Retainers

**Dental Fillings:**

Cosmetic Composite Bonding

(White Fillings)

Amalgam (Silver) Fillings

Inlays/Onlays

Silver Diamine Fluoride

**Dental Sealants**

**Crowns & Bridges**

**Porcelain Veneers**

**Teeth Whitening**

Custom At-Home Bleaching

Custom In-Office Power Bleaching

Over-The-Counter Rx Products

**Root Canal Therapy Services**

**Denture Services** (Complete & Partial)

**Night/Brux Guards**

**Athletic Sport Guards**

**Dental Sleep Medicine Appliances**

**Dental Extractions (including wisdom teeth)**

**Surgical Services:**

Bone Augmentation

Sinus Elevation

Tooth Exposure

**Dental Implants:**

Implant supported Crowns/Bridges

**Full Mouth Rehabilitation Services:**

Implant supported Partial Dentures

Implant Supported Removable Overdentures

Implant Retained Fixed Hybrid Dentures

**Sedation Dentistry:**

Oral Conscious Sedation

IV Sedation

**Same Day Services:**

Emergency Situations

Denture Repairs

CEREC Same Day Crowns/Inlays/Onlays

**Patient’s Rights & Responsibilities**

### Patient’s Bill of Rights

You have the right to:

* Considerate, respectful, and timely care without any discrimination that meets or exceeds the Standard of Care.
* Be treated in a safe, clean, and smoke-free environment.
* Privacy concerning your dental treatment. Discussions concerning your care will remain confidential between you and the doctors and staff at Cornerstone Dental. No information will be disclosed regarding your treatment without your prior written authorization, unless required by law.
* Receive current and complete information regarding the diagnosis and treatment of your dental condition(s), including its prognosis, in terms you can understand.
* Know the detailed treatment plan, alternatives, risks and benefits concerning your dental condition, along with the estimated cost of such treatment, sufficient to give us your informed consent before any treatment is started.
* Participate in all decisions about your treatment.
* Refuse treatment suggested for you and the right to know the risks of refusal.
* Expect that your care meets the Standards of Care of the dental profession.
* Prompt treatment and continuing care after you have reached a maintenance level including follow-up care.
* Continuity and completion of your dental treatment. You have the right to emergency care as needed.
* Access to your dental records upon request and to have the information explained or interpreted.
* Request and examine any financial statement regarding your treatment.

**Patient Responsibilities**

In order for Cornerstone Dental to provide you with the best and most efficient care possible, it is very important that you fulfill your responsibilities as a patient. You have the responsibility to:

* Provide, to the best of your knowledge, complete and accurate information regarding your present health, past illnesses and hospitalizations, medications, dental concerns, and any other matters pertaining to your health.
* Report any changes in your health since your last appointment to your hygienist and/or dentist.
* Inform us if you do not fully understand your dental condition, the proposed treatment to be rendered, the risks and benefits associated with the proposed treatment and alternatives to your proposed treatment, and associated fees.
* Follow any and all recommended instructions, including preventive home care techniques and follow-up treatment, given to you.
* Be prompt for your scheduled appointments. We reserve specific time for you and make every effort to respect that your time is valuable. If you are unable to make a scheduled appointment please contact us with 48 hours notice.
* Discharge your financial obligations to Cornerstone Dental. This includes disclosing information for changes in insurance carrier or discontinuation of dental insurance.
* Ensure that the financial obligations of your care are fulfilled as promptly as possible.
* Ask questions when you do not understand information or instructions given to you.
* Be considerate of the rights of other patients by controlling noise and respecting a smoke-free environment.
* Bear the responsibility for any harm to your oral health or untoward reactions that may result from the refusal of treatment, although it is your right to refuse proposed treatment.

**CORNERSTONE DENTAL, LLP - NOTICE OF PRIVACY PRACTICES**

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.

We are required by law to maintain the privacy of protected health information or PHI, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 1, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice. The privacy of your health information is important to us.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We may use and disclose your PHI for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use/disclose your PHI for your treatment. For example, we may disclose your health information to specialists providing treatment to you as well as dental labs, etc.

**Payment.** We may use and disclose your PHI to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your PHI in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your PHI to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your PHI to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your PHI when we are required to do so by law.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Public Health Activities.** We may disclose your PHI for public health activities, including disclosures to:

* Prevent or control disease, injury or disability;
* Report child abuse or neglect;
* Report reactions to medications or problems with products or devices;
* Notify a person of a recall, repair, or replacement of products or devices;
* Notify a person who may have been exposed to a disease or condition; or
* Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**National Security.** We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody, the PHI of an inmate or patient.

**Secretary of HHS.** We will disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker’s Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

**Other Uses and Disclosures of PHI.** Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

# YOUR HEALTH INFORMATION RIGHTS

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your PHI in accordance with applicable laws and regulations. To request an accounting or disclosures of your health information, you must submit your request in writing to the Privacy Official listed at the end of this Notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan) has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your PHI by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations have you requested, we may contact you using the information we have.

**Amendment.** You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

**QUESTIONS AND COMPLAINTS**

If you would like more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Stacy Demchock ▪ Email: [stacydemchock@cornerstonedentalny.com](mailto:stacydemchock@cornerstonedentalny.com) ▪ 3770 Mt. Read Blvd. ▪ Rochester, New York 14616 ▪ (585) 865-7030 ▪ Fax (585) 865-1425

**Office Appointment Policy**

To help us serve you better, our office hours are by appointment only. Because of the nature of our work and the time necessary for proper implementation of each procedure, each hour of our workday is precious and carefully scheduled. We appreciate and respect the value of your time and will do our very best to be on time for you. We appreciate the same courtesy in return as we reserve time for you in our schedule. In order to see you at your scheduled time, please be prompt for all of your appointments. Additionally, when indicated, please forward or bring the following with you to your next appointment if you have not done so already. You may also send to info@cornerstonedentalny.com.

* Any recent x-rays taken in the last year at other offices. If unavailable, we may take our own x-rays.
* All medical information including any medications, surgeries, etc.

**Missed or Cancelled Appointments**

Our goal is to provide treatment in a timely manner with as few visits as necessary. Additionally, a missed or broken appointment by one person is a lost opportunity to help another in need of care. We understand that unforeseen circumstances may arise which may result in cancelling or missing your appointment, however, we require and can accommodate 48 hours (2 working days) notice for cancellations or for re-scheduling your appointments.

A charge may be assessed for multiple missed or “short notice” rescheduled/cancelled appointments. Multiple failed appointments may erode the doctor-patient relationship and result in being dismissed from the practice.

Broken or cancelled appointments with less than the required 48-hour (2 working days) notice in a **6-month period** may result in the following charges:

* **1st broken or “short notice” rescheduled/cancelled appointment:**
* No charge
* **2nd broken or “short notice” rescheduled/cancelled appointment:**
* Hygiene appointment: $25 charge
* Dentist appointment: $50 charge
* **3rd broken or “short notice” rescheduled/cancelled appointment:**
* Hygiene appointment: $50 charge
* Dentist appointment: $100 charge
* Account will be reviewed and continued care will be at the discretion of your primary oral health care provider

I certify that I have read this policy, or that it has been read to me, and that I understand the above. I have had an opportunity to ask questions and had these questions addressed to my satisfaction.

* Patient (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_
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Signature of Patient (or Person Authorized to Sign for Patient) Relationship to Patient

**Office Financial Policies, Insurance & Assignment of Benefits**

In an effort to continually provide prompt, high quality care at competitive fees, Cornerstone Dental, LLP expects that payments be made at the time services are rendered. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment being rendered.

**FINANCIAL POLICY:**

1. Before any treatment is performed, we will discuss treatment options to include the risks and benefits of each, as well as financial options. This will help you to fully understand your dental treatment, what to anticipate in fees, and allow you time to make any necessary financial arrangements.
2. Payment is due at the time service is provided.
3. Treatment Plans may change, but you are responsible for the treatment actually completed.
4. Large cases (≥$1000) as well as cases associated with lab services require a down payment or “reservation fee” prior to starting treatment.
5. Our office accepts the following payment options:

* Cash
* Personal checks (additional fees will be applied for returned checks)
* Visa, MasterCard, Discover, American Express
* Third-party financing such as CareCredit (available upon request and approval)
* Payment Plan Options (requires approval)

1. Any/all account balances over 90 days are subject to a $35.00 late fee.
2. Accounts where payment arrangements are in default are subject to a $35.00 fee.
3. A $35.00 charge will be billed to accounts for any returned checks by the bank for any reason.
4. If sent to Collections due to non-payment, you agree to pay any/all related legal fees and court costs.

**DENTAL INSURANCE:**

As a courtesy to you, we will process all of your dental insurance claims and do all that we can to help you maximize your insurance benefits. We will provide you with an estimate regarding reimbursement, but cannot guarantee coverage for recommended or provided procedures due to the complexities of insurance contracts. Insurance coverage is subject, but not limited to, plan limitations, exclusions, waiting periods, frequency restrictions, age restrictions, deductibles and maximums. These are parameters within your plan, out of our control, and ultimately between you and your insurance company. Please contact your insurance company for a detailed breakdown of your benefits.

Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible, however, your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.

* All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
* Our practice is committed to providing the best treatment for our patients and our fees are considered usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.
* We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form allows us to release your treatment information to your insurance company and instructs your insurance company to make payment directly to our office (when indicated/applicable). By signing this Financial Policy, you authorize the release of any information concerning you (or your child’s) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
* When indicated, we ask that you pay any deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express or 3rd party financing (ie. CareCredit) at the time we provide service to you.
* Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount.
* We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Please ask any one of our courteous and knowledgeable team members about our various payment options. We will try to help with any insurance questions, but questions regarding your insurance benefits should be directed to your insurance carrier.

**EMERGENCY PATIENTS:**

Emergency patients, new to our practice, are expected to make payment at the time service is provided.

**MINORS ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN:**

The parent or legal guardian accompanying a minor, who has consented to treatment, is responsible for full payment at time of service.

\*\*\*Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

**COMMUNICATIONS WITH YOU:**

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We, or our agents, may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

**CONSENT:**

I have read, understand, and hereby agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office (when indicated/applicable). I understand that responsibility for payment for dental services provided in this office for myself or my dependents is ultimately mine, regardless of any possible insurance reimbursement, and unless prior arrangements have been made, due and payable at the time services are rendered. I hereby authorize and instruct Cornerstone Dental, LLP to request direct payment from my insurance carrier (when indicated/applicable), for benefits (payments) on services rendered. I further agree, when applicable, to forward to Cornerstone Dental, LLP any insurance reimbursements sent directly to me for services rendered.

I understand that an estimate of benefits from my insurance company is not a guarantee of coverage or payment. I acknowledge I am responsible for and agree to personally pay for any services that are not covered by or collected from any insurance program, including any deductibles and coinsurance amounts.

It is understood and agreed that I am responsible for reasonable attorneys’ fees incurred by Cornerstone Dental, LLP in the collection of a delinquent account. It is further understood and agreed that 25% of the outstanding balance shall represent Cornerstone Dental, LLP’s reasonable attorneys’ fees.

* Patient (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_
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Signature of Patient (or Person Authorized to Sign for Patient) Relationship to Patient

**Informed Consent for Dental Procedures**

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedures, alternative treatments, or the option and risks of no treatment.

It is very important that you provide your dentist with accurate medical and situational information before, during and after treatment. It is equally important that you follow your dentist’s advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Please do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered to your satisfaction. By consenting to treatment, you acknowledge your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

**CONSENT:** I hereby request and authorize Cornerstone Dental, LLP, any associate dentists, hygienists, assistants, and/or such other qualified personnel as may be selected, to perform examinations and any diagnostics including radiographs (x-rays), dental care/procedures, and/or any other therapeutic procedure(s) that is in his/her judgment, advisable within the standard of care.

I will seek to understand the rationale as well as the nature and purpose of the recommended procedures, the risks involved, and the possibility of complications. I acknowledge that no guarantee or assurance has been made as to any results that may be obtained. Further, I understand that during treatment, it may be necessary to change or add procedures because issues may be found while working that were not discovered during the initial examination, the most common being root canal therapy following routine restorative procedures. I understand that these procedures may come with additional costs. I give my permission to the dentist to make any or all changes and additions as necessary.

I understand the advantages and inherent risks of anesthesia and I authorize the administration of such anesthesia as may be considered necessary or desirable.

I authorize that any specimens, tissue, or parts removed from me, or the patient for which I am signing, be handled or disposed of in accordance with established practice.

In some instances, a referral to a specialist may be indicated. If I, or the patient for which I am signing, requires the services of a specialist, I agree to accept the referral and will be responsible for any expense that may be incurred.

I understand that dentistry is not an exact science and that many factors outside of the dentists’ control can influence a positive outcome, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist other than the treating dentist is responsible for my dental treatment. I certify that I have read this consent, or that it has been read to me, and that I understand the above. I have had an opportunity to ask questions and had these questions addressed to my satisfaction.

* Patient (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_
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Signature of Patient (or Person Authorized to Sign for Patient) Relationship to Patient

**Informed Consent/Authorization for**

**Use and Disclosure of Patient Name, Photographs, Voice, and/or Video Images**

We pride ourselves on being a fun, friendly, and dynamic office. We frequently take pictures and videos and post to our website as well as to social media sites, such as Facebook and Instagram, to show off the services we provide and the results we get. Thank you for choosing Cornerstone Dental, LLP for all your oral health care needs and for agreeing to help us!

**Authorization:**

I authorize the use and disclosure of my name, photograph or video images, voice recording, including testimonials and biographical information, for marketing and advertisement purposes by the company listed above and their affiliates. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure and also may no longer be protected by HIPAA privacy regulations. I have reviewed this carefully and authorize the following checked boxes:

## Teeth ONLY Face First Name

* **Before & After Photos:** 🞏 🞏 🞏

**Research, Training,**

**Lectures, or Case Studies:** 🞏 🞏 🞏

**Promotions / Marketing**

**(Website, Facebook, Instagram,**

**Brochures, Contests, etc.):** 🞏 🞏 🞏

**Purpose:**

The photographic or video images, voice recordings, testimonials or biographic information may be used in any of the following manners: Internet websites, social media, print, digital, television or internet for advertising or marketing.

**Revocability:**

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the company via registered mail at 3770 Mt. Read Blvd, Rochester, NY 14616 and effective five business days after mailing. I understand that my written revocation only applies to the disclosure of my image/voice after the effective date of receipt of my written revocation and is not retroactive to the date of my original consent. In the absence of written notice of revocation, this authorization expires 99 years from date signed.

**No Treatment Conditions:**

I understand that the company cannot condition treatment on whether or not I sign this authorization and that I sign this consent freely.

Only as indicated above, I authorize the use of my photographs, videos, and/or name without compensation to me. I hereby release the photographer and Cornerstone Dental, LLP from all claims and liabilities with regard to the use of my name and any images, videos. A copy of this executed form has been provided to me.

* Patient (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Person Authorized to Sign for Patient) Relationship to Patient

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

Cornerstone Dental, LLP’s Notice of Privacy Practices provides information about how protected health information (PHI) about me (the patient) may be used or disclosed. I have been offered an opportunity to review the Notice, object to the use or disclosure of my PHI, and/or request restrictions as to how my PHI may be used or disclosed for treatment, payment, or healthcare operations before signing this consent. Cornerstone Dental, LLP is not required to agree to any restrictions, but if they agree, will be bound by the agreement. I understand that the terms of the Notice may change and I may obtain a revised copy by contacting the office at (585) 865-7030 or by visiting the office’s website at [www.cornerstonedentalny.com](http://www.cornerstonedentalny.com).

I authorize Cornerstone Dental, LLP to discuss and/or release my PHI to the following individuals:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I wish to have the following restrictions regarding the use and/or disclosure of my PHI:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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By signing below, I acknowledge that I have received a copy of and understand Cornerstone Dental, LLP’s Notice of Privacy Practices.

* Patient (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Person Authorized to Sign for Patient) Relationship to Patient

**FOR OFFICE USE ONLY**

Attempts were made to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because:

* Individual refused to sign
* Communication barriers prohibited obtaining acknowledgement
* An emergency situation prevented us from obtaining acknowledgement
* Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_

EE Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_