CONSENT and RELEASES

- I hereby authorize Dr. Jaclyn S. Blyholder and/or team to take photographs, slides, and/or videos of my face, jaws and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care and treatment, and hereby authorize their use for educational purposes in future lectures, professional marketing and demonstrations by Dr. Jaclyn S. Blyholder and/or team. I further understand I will receive no further financial compensation for the use, at any time in the future, of my testimonials, photos, slides, or videos by Dr. Jaclyn S. Blyholder and/or team.

- I authorize Dr. Jaclyn S. Blyholder and/or team to release any information, including the diagnosis and the records of any treatment or examination rendered to me, or my child during the period of such Dental care to the third party payors, and/or health practitioners.

- I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICE. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. I understand that my dental insurance is a contract between my insurance carrier, and me and not between Dr. Jaclyn S. Blyholder and my insurance carrier. I understand that I will be charged for all dental treatment, and that any payments received by the Dental Office will be credited to my account or refunded to me if I paid the dental fees incurred. I am responsible to pay any co-payments, deductibles, or unpaid balances from my insurance, and that waiving or forgiving co-payments and deductibles is unethical and illegal. I understand if the account is turned over to an agency or other entity for collections, all fees, costs and interest, including but not limited to attorney's fees and costs incurred to the collection activity will be added to the balance according to the terms of this Agreement.

- In the event payments are not received by agreed dates, I understand a 1.5% finance/Accounting fee (18% APR) may be added to my account. I agree to pay any and all charges incurred if a check or other payment is returned or refused for any reason.

- I hereby authorize Dr. Jaclyn S. Blyholder and/or staff to take x-rays, study models, and other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of (patient) _____'s dental needs. Upon such diagnosis, I authorize Dr. Jaclyn S. Blyholder and/or team to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required, providing proper care. I hereby authorize Dr. Jaclyn S. Blyholder and/or team; to administer such medicines, and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand I can ask for a recital of possible complications. I have been a patient of Dr. Jaclyn S. Blyholder. During the course of our dentist – patient relationship, I participated with Dr. Jaclyn S. Blyholder in a co-diagnosis video examination of my oral cavity. Such co-diagnosis involved Dr. Jaclyn S. Blyholder examining my teeth using an intra-oral video camera, displaying the pictures of my teeth on a TV monitor, and identifying areas of cavities, decay, or lesions on my teeth, and my acknowledging my understanding of such identification.

  Following such diagnosis, Dr. Jaclyn S. Blyholder explained to me the options available for treatment of such cavities, decay, or lesions. In consultation with Dr. Jaclyn S. Blyholder, after discussion of those options, I made the final determination of the progression of care, including scheduling of restorations in accordance with my personal needs or circumstances.

- I agree that my signature below can be used as a signature on file to process all future insurance claims.

- I have read and understood this entire agreement before signing here below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice.

_____ _____

Patient or Responsible Party Date

PRE-TREATMENT CHECK LIST

- **YOU WILL NOTICE OUR OFFICE IS DIFFERENT**. We offer the highest level of dental technology possible. We are constantly seeking education to keep up with the best dental services available. We are proud of our fees because they reflect the quality of care, level of education, service we provide, and the overall time we devote to each patient.

- **YOU HAVE THE RIGHT TO ASK ABOUT THE TYPE OF TREATMENT YOU ARE RECEIVING, EXPECTED COSTS, AND ALL TREATMENT OPTIONS (INFORMED CONSENT).** It is imperative that you ask at the time of scheduling, or anytime prior to being treated. Dr. Jaclyn S. Blyholder and/or team do their best to explain what your needs are, and how best to treat them. Dr. Jaclyn S. Blyholder and/or team, or other instructional materials, will inform of any suitable treatment alternatives, including doing no treatment at all, any risks and relative costs. If you arrive for treatment and have any questions, or were not fully informed of any of these concerns, please let us know before any treatment is performed, and we will cheerfully attempt to answer any of your questions.

- **YOU HAVE A RIGHT TO SEE THE DOCTOR EACH VISIT IF YOU WISH.**
  The office dental auxiliary performs certain aspects of dental treatment, while Dr. Jaclyn S. Blyholder is present in the office. If at any visit, you wish to see Dr. Jaclyn S. Blyholder, please inform us and we will gladly make the time to address your concerns.

- **WHITE RESTORATIONS (Fillings)**
  With the advent of the new remarkable tooth colored restorative materials (fillings) available, and the vast number of advantages, and therapeutic benefits over traditional silver fillings, this office **virtually always uses white restorative materials on both front and back teeth.** Insurance coverage and philosophies vary on reimbursement of these services. We require that the patients concerned with costs, coverage, co-payments inquire prior to treatment. If you wish to use alternative materials, inform us prior to scheduling treatment.

- **POST OPERATIVE NEEDS**
  No two patients are exactly alike. We all have different genetic make-ups, diverse healing capabilities, and unique dental and anatomical differences. Teeth are living tissue, and anytime the dentist treats the tooth with a hand-piece, there is some possibility of pulpal trauma, which in some cases may necessitate further treatment. Dentistry is not an exact science, and our treatments, while utilizing the most up-to-date techniques and materials, **may result in unforeseen, unpredictable, post operative conditions, requiring additional care, additional procedures and possibly additional costs**, to return your oral conditions to a state of optimal health. Dr. Jaclyn S. Blyholder and/or team, with their diagnostic tools and treatment planning will always strive to make the outcome of dental therapy as predictable as possible.

- **CANCELLATIONS**
  We understand that emergencies do arise. We ask that you provide us with **24 business hours** advance notice for any cancellations of any of your appointments in order to avoid the imposition of cancellation fees, which are determined by the length and type of service being rendered at the scheduled visit. Such cancellation fees are **non-refundable**.

- Understanding this, I hereby authorize Dr. Jaclyn S. Blyholder, other practitioners whom he recommends, or qualified auxiliaries to accomplish such treatment for me.

- I would like the office to recognize this understanding as long as I am an active patient.

_____
Name of Patient

_____ _____
Signature (Responsible Party) Date