HUDSON HEADWATERS
ALBERT R. TUCKER DENTAL CENTER

☐ Patient or Legal Representative refused to sign/complete this document.

GENERAL DENTAL CONSENT AND AGREEMENT

We have developed the following agreement to ensure a long and healthy relationship together. Please read the following information carefully. After you have read this consent and agreement, please sign your name indicating your acceptance of the terms of this agreement. By signing this document, you understand the agreement and consent in full, and you have had all of your questions answered to your satisfaction.

- I, _____ (*Patient's name*), _____ (*date of birth*) agree to permit the providers, residents, learners and staff of Hudson Headwaters Health Network (HHHN) to provide dental care to myself, child or legal ward as applicable.

- I understand that HHHN offers prevention-focused care, with limited appointments available for filings and other services.

- I agree to abide by HHHN's *Patient Responsibilities* and understand that these responsibilities are posted in all health centers, online and physically available to me upon request.

- I understand that HHHN maintains the right to discontinue treatment for any violation of these responsibilities, such as failure to maintain a consistent appointment schedule or inappropriate behavior. In such cases, the patient or parent/guardian agrees to accept full responsibility for pursuing alternate professional dental care.

- By signing below, I am indicating that I understand the terms of the consent agreement and that I have the legal authority to give consent for myself, child, or legal ward. I hereby give consent to HHHN to perform these procedures:
    - Examination
    - Oral prophylaxes (cleaning)
    - Radiographs (x-rays)
    - Local anesthesia
    - Fluoride treatments
    - Sealants
    - Oral hygiene instructions
    - Periodontal (gum) treatments
    - Restorations (amalgam or composite fillings and crowns)
    - Prosthetics
    - Emergency Care

- I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.

- I understand that any dental procedures not listed above will require an additional consent and agreement to be completed prior to the procedure being performed.

- I understand that my care team may include dental residents, students or other trainees. A dental resident is a doctor who has graduated from dental school and is undergoing further clinical training. I understand that the dental resident may perform all or parts of my care. I understand that I have the right to refuse this arrangement at any time.

- I understand my provider leverages technological tools and resources including those which leverage artificial intelligence in the delivery of my care.

- I agree to emergency care as necessary, and the services performed at the request of my providers, residents or others assisting in my care. I understand that I have the right to refuse treatment at any time.

- I understand that dentistry is not an exact science and as such, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment plan which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction.

_____	_____	_____
Signature of Patient or Representative Authorized by Law	Print Name	Date

HUDSON HEADWATERS HEALTH NETWORK

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Phone Number

Street Address	City	State	Zip Code

A) I hereby authorize records FROM:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

B) To be released TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

C) Information disclosed: *(please select one)*

☐ Medical information ☐ Dental information

- -

☐ Entire record set

☐ Date range: _____ to _____

☐ Other: _____

D) Special Considerations:

To include the following information, please initial below. If not initialed, this information will not be disclosed.

_____ Alcohol/Drug treatment

_____ HIV/AIDS-related information

_____ Mental health treatment

E) Purpose of requested information: *(please select one)*

☐ At the request of the individual ☐ Transfer of care *(select reason)*

☐ Legal purposes ☐ Patient experience ☐ Other: _____

☐ Coordination of care ☐ Patient relocation

F) Delivery method: *(please select one)*

☐ US mail (Paper) ☐ US mail (CD) ☐ Pick up at: _____

☐ Encrypted email: _____ ☐ Fax to: _____

G) Authorization Expiration: Unless previously revoked by me in writing, this authorization will expire on the following date or event: _____ *Please note: If left blank, this authorization will expire upon the completion of the release of information outlined in this document.

H) If not the patient, name of person signing authorization:	I) Authority to sign on behalf of patient:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

This authorization may include disclosure of information relating to **ALCOHOL/DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **HIV RELATED INFORMATION** only if I place my initials on the appropriate line in the Special Considerations section. In the event the health information described above includes any of these types of information, and I initial the line in the Special Considerations, I specifically authorize release of such information to the person(s) indicated in Item B.

If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at **(212) 480-2493** or the New York City Commission of Human Rights at **(212) 306-7450**. These agencies are responsible for protecting my rights.

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be redisclosed by the recipient (except for the Special Considerations as noted above), and this redisclosure may no longer be protected by federal or state law.

HHHN reserves the right to charge the 'medical record stated fee structure' as set forth in the NYS Article 18 Public Health Law. By signing this authorization, I agree to pay HHHN for my records if applicable.

_____ _____ _____

Signature of Patient or Representative Authorized by Law | Print Name | Date

HUDSON HEADWATERS
ALBERT R. TUCKER DENTAL CENTER

☐ Patient or Patient Representative refused to sign/complete this document.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of the Hudson Headwaters Health Network (the Network) Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how the Network may use and/or disclose my personal health information both with and without my authorization. I further understand that the Network reserves the right to change its privacy practices at any time. In the event of a change, a copy will be posted in a prominent location in the practice site, or upon my request, a copy will be sent to the address I have provided.

I understand that as part of my health care, the Network originates and maintains paper and/or electronic records describing health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means to facilitate coordination of care among the health professionals, including referrals, who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for healthcare options of the Network such as assessing quality of care and reviewing competence of healthcare professionals.

I understand that the Network may send test results and correspondences associated with my care to the address I have provided. The Network may also leave messages at the telephone numbers I have provided either to confirm appointments or to request I call on treatment or administrative matters.

If you require a restriction on the above, please see a staff member at the front desk.

_____	_____	_____
Signature of Patient or Representative Authorized by Law	Print Name	Date

HUDSON HEADWATERS
ALBERT R. TUCKER DENTAL CENTER

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RELEASE OF DENTAL INFORMATION AND ASSIGNMENT OF BENEFITS

I understand that my health information may be used or disclosed for the purposes of treatment, payment, and operations in accordance with state and federal regulations for privacy and security. I understand that this may include disclosures of information to my insurance carrier(s), including Medicare, private insurance, and any other dental/health plan, to issue payment directly to the Network for services rendered to myself and/or my dependents. I am responsible for understanding the limitations of my insurance coverage and to present any co-pay, co- insurance, deductible or other personal obligations at the time service is rendered. I acknowledge that any expenses not covered under an insurance policy will be my responsibility. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Additionally, I give the Network permission to disclose to a relative or friend my location and general condition, or other information directly relevant to that person's involvement in my care[1], to those I have named below:

_____ _____
(First and last name) *(Relationship to patient)*

_____ _____
(First and last name) *(Relationship to patient)*

_____ _____
(First and last name) *(Relationship to patient)*

Please note: this document **does not expire** and is considered to be in effect unless the patient/personal representative updates or revokes it in writing. Furthermore, this document only applies to dental-related information and does not include the release of medical information.

_____ _____ _____
Signature of Patient or Representative Authorized by Law | Print Name | Date

HUDSON HEADWATERS HEALTH NETWORK

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DETERMINATION OF FAMILY SIZE AND INCOME

The Network serves all patients and does not deny services based on patients' ability to pay. The Network also offers discounted fees for patients who qualify for our sliding fee program. Because the Network receives funding from the Federal Government to offer these services, we are required to collect income range information for all patients.

Please determine family size and check the appropriate income category box.

FAMILY SIZE	CATEGORY 1: ☐	CATEGORY 2: ☐	CATEGORY 3: ☐	CATEGORY 4: ☐
1	$0-15,650	$15,651-23,475	$23,476-31,300	$31,301
2	$0-21,150	$21,151-31,725	$31,726-42,300	$42,301
3	$0-26,650	$26,651-39,975	$39,976-53,300	$53,301
4	$0-32,150	$32,151-48,225	$48,226-64,300	$64,301
5	$0-37,650	$37,651-56,475	$56,476-75,300	$75,301
6	$0-43,150	$43,151-64,725	$64,726-86,300	$86,301
7	$0-48,650	$48,651-72,975	$72,976-97,300	$97,301
8	$0-54,150	$54,151-81,225	$81,226-108,300	$108,301

Please note: this table is based on Federal Poverty Guidelines (FPG) which are released every year. This form must be **updated** and **completed** annually in accordance with Uniform Data System requirements.

_____ _____ _____

Signature of Patient or Representative Authorized by Law | Print Name | Date