All Smiles Tampa Bay
Family & Cosmetic Dentistry

Joseph N. Grimaudo, DMD
Melissa M. Grimaudo, DMD

Patient Name: ______________________________ Date of Birth: ______________

Consent to Office Policy

The staff at All Smiles Tampa Bay is committed to providing outstanding dentistry. By consenting to the treatment recommended by the dentist, you are helping us to maintain an extraordinary level of care.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that anesthetic agents embody certain risks. I understand that I can ask for a complete recital on any possible complications.

I understand a treatment option is to receive no treatment. I also understand that I have a right to refuse any treatment recommended by signing a separate refusal of treatment consent form consisting of risks of no treatment. I further understand that unwillingness to sign a refusal of treatment form or refusal of multiple recommended treatments could lead to dismissal from the practice.

During the course of treatment, conditions not evident during examination may necessitate procedures different from those planned and may need a specialist for necessary treatment. I understand that I will be notified of any necessary treatment changes as well as cost differences. I understand any costs incurred from a specialist are my responsibility.

Photography is used as a means of communication between dentist and patient, as well as other treating dentists/specialists and dental labs. Occasionally the doctors will use non-identifying photographs for educational purposes including study groups and case studies.

Dentistry is not an exact science and that no specific results be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand the waiting on treatment needed may compromise the treatment initially proposed, which may necessitate more extensive treatment or procedures.

Notice of Privacy Practices (HIPAA)

We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of Privacy Practices with respect to that information. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

There are certain circumstances under which we may use or disclose your health information without first obtaining your acknowledgement or authorization. These include treatment, payment, and health care operations.
Treatment: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain pre-authorization or payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with operations such as quality assessment, public health and law-enforcement activities. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We must also provide health information when ordered by a court of law to do so.

Others Involved in Your Healthcare: We may disclose protected health information, including treatment plan, treatment alternatives, or payment information to a person or family member who is involved in your medical/dental care or payment for your care. If you do not wish this information to be shared, please notify the office. In addition, we may use your information to remind you of appointments by sending emails, texts, postcards and/or leaving messages at home and/or work.

You have certain **rights regarding your health record information**. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We will consider your request but are not legally required to accept it. You have the right to inspect, copy and request amendments to your health records. You must submit a written request regarding the information you would like to inspect or amend. We will not alter our documents, but we will add your statement to your file. We will charge a reasonable fee for providing a copy of your health records. You have a right to receive a copy of this notice.

We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.
Please contact our office if you feel your privacy rights have been violated. More information is available at the U.S. Department of Health and Human Services web site, http://www.hhs.gov/ocr/hipaa.

I have read the above information, have had the chance to have all my questions answered and I certify that I understand. I hereby give consent for the treatment I have chosen.

Signature ______________________________ Date ______________