

## **Informed Consent for Oral Cancer Screening**

Vizilite System is used as an aid in the early detection of mucosal abnormalities. Use of this natural tissue fluorescence will detect and manage oral soft tissue conditions. This system helps us to perform a more comprehensive examination. Early detection impacts disease mortality and facilitates minimally invasive treatment procedures. Unfortunately, there is a 5-year survival rate with little improvement over the past 30 years, mainly because a significant proportion of cancers being diagnosed late (stage III and IV). Vizilite provides a potential to include cancer screening and detection of oral cancer in its early stages.

This procedure is highly recommended for a patient that uses tobacco in any form or has any family history of cancer. This procedure is sometimes covered by private insurance companies for preventative services. The fee for this service is \$50.00 and will greatly be reimbursed by detecting the early stage of a cancerous lesion.

This office recommends this procedure as part of your annual examination.

Please sign below stating your decision about the Vizilite examination:

*I <u>WILL</u> have the screenin	g for possible lesions of oral abnormalities.	
Printed Name	Signature	Date
*I <u>WILL NOT</u> have the scre	eening for possible lesion of oral abnormali	ties.
Printed Name:	Signature	Date



## Written Financial Policy

Thank you for choosing Herb Bennett, DMD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

## Payment Options:

You can choose from:

- Cash, Check, Visa®, MasterCard®, American Express® or Discover Card®
- Convenient Monthly Payment Options¹ from CareCredit Healthcare Credit Card
  - o Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

<sup>1</sup>Subject to credit approval

Herb Bennett, DMD requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.<sup>2</sup>

A fee of \$25 is charged for patients who miss or cancel more than 3 times in a calendar year without 24-hour notice.

Herb Bennett, DMD charges \$30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature	Date	
• • • • • • • • • • • • • • • • • • • •		
3000000 00 00 00 00 00 00 00 00 00 00 00		

<sup>2</sup>However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Herb L. Bennett, DMD 120 East Dixie Ave Leesburg, Florida 34748 352-787-7890 352-787-9036

DATE

## Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

I understand that under the Health Insurance Portability and Accountability certain Patient Rights regarding my protected health information.	Act of 1996 (HIPAA), I have			
I understand that Herb L. Bennett, DMD, PA may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patie handling billing and payment; and, taking care of other health care operations. Unless required by law there will be no other uses and disclosures of this information without my authorization.				
Herb L. Bennett, DMD, PA has a detailed document called the 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.				
I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Herb L. Bennett, DMD, PA will provide me with the most current Notice of Privacy Practices.				
My signature below indicates that I have been given the chance to review such copy of the <i>Notice of Privacy Practices</i> . My signature means that I agree to allow Herb L. Bennett, DMD, PA to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Herb L. Bennett, DMD, PA has taken action relying on this consent.				
SIGNATURE (Patient or Legal Custodian/Authorized Representative)	DATE			
Relationship to Patient if signed by another party	DATE			
You may obtain a copy of our <i>Notice of Privacy Practices</i> , including any revisitime by contacting: Herb L. Bennett, DMD, 120 E. Dixie Ave, Leesburg, Florid	sions of our <i>'Notice'</i> at any da 34748, 352-787-7890.			

FORM Us

PATIENT NAME