Consent Form

Consent to Treat:
I consent to the treatment and procedures that may be performed during my appointment. I have the right to make informed decisions about my healthcare, including the refusal of a treatment or procedure. I understand healthcare students may participate in my care.

Consent to Share Medical Records:
I understand that my medical record could be shared with the different departments of Family Healthcare of Hagerstown. This information will be shared only to help in my health care assessment and management.

I understand that at any time during the course of my medical treatment, if a referral to a specialist is required, certain laboratory results and/or details from the medical record could be forwarded to the specialist. This will be done solely to assist in my complete evaluation.

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions. You may "opt out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or by completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crsisphealth.org.

Confidentiality:
I understand that Family Healthcare of Hagerstown adopts a very strict policy regarding privacy and confidentiality of my medical information. I have been given information regarding the Notices of Privacy Practices.

Medical Insurance Authorization and Assignment:
I understand all charges are due at the time professional services are rendered. I authorize Family Healthcare of Hagerstown and all its included entities, to furnish information to my insurance carriers concerning my illness and treatments. For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to Walnut Street Community Health Center, Inc., DBA Family Healthcare of Hagerstown. I understand I am responsible for any amount not covered by insurance, to include co-pays and fees.

I understand that Financial Assistance is available to qualifying patients.

Acknowledgement:
I acknowledge that I have received the Patient Information Guidelines and Patients' Rights and Responsibilities and agree to abide by the policies of Family Healthcare of Hagerstown.

Consent to give permission to administer Nitrous Oxide
The purpose of this Informed Consent is to provide an opportunity for patients, parents or guardians, to understand and give permission for the use of Nitrous Oxide when provided along with dental treatment.

- Nitrous Oxide is commonly called laughing gas and provides relaxation, although the patient will be awake, fully conscious, aware of surroundings and able to respond rationally to questions and directions.
- Nitrous Oxide is not required to provide the necessary dental care.
- The purpose of Nitrous Oxide is to make the patient more comfortable to receive the necessary dental care with less pain and/or anxiety.
- Nitrous Oxide has limitations and will be administered by way of inhalation route and risks and absolute success cannot be guaranteed.
- Nitrous Oxide has been fully explained to me, including all risks involved. I have been fully informed that temporary complications may include, but are not exclusive of: tingling in the fingers, toes, cheeks, lips, tongue, head or neck area; heaviness in the thighs and/or legs, followed by a lighter floating feeling; resonation in the voice or presence of a hyper-nasal tone; warm feeling throughout body, with flushed cheeks; fits of uncontrollable laughter or giddiness; detachment or disassociation from environment may occur; lightweight or floating sensation with an accompanying "out of body" sensation; sluggishness in motion and slurring and/or repetition of words; feeling of nausea; vomiting; agitation; and/or hallucination. All of these complications are temporary.

My signature indicates that I have read the above consent for Nitrous Oxide and give my permission for myself/my child to have this administered, if necessary. I have informed the dentist of my/my child's complete medical history including any recent surgeries or changes in their medical history involving lung, respiratory, ear infection or common cold. I have also informed the dentist if I/my child is pregnant. I understand that for all private insurances Nitrous Oxide sedation is not a covered service. I agree that I will be responsible for the fee of $63.00 unless I am on the $40.00 slide through FHH. I agree to pay for this at the time of service.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

I understand that this consent, in its entirety, will remain in effect as long as I continue to receive health care services at Family Healthcare of Hagerstown.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____ _____

Printed Name of Patient Signature of Witness