Edward J. Sharkey, D.M.D.
3201 Rogers Ave. Suite 202
Ellicott City, Maryland 21043
410-465-6008
410-465-5507

Patient's
Name_____
Last First MI Birth Date

General Consent

I hereby authorize **Edward J. Sharkey D.M.D., LLC,** and whomever he may designate as his assistants, to perform upon me the following operations and/or procedures:

Comprehensive dental treatment to include but not limited to simple and complex restorative dentistry, endodontic procedures (root canals), oral surgery, periodontal therapy and preventive maintenance therapy, including dental x-rays.

I request and authorize him/her to do whatever he/she deems necessary if any unforeseen condition arises in the course of these designated operations and/or procedures based solely in their judgment for procedures in addition to or different from those originally contemplated and I agree to pay for said unforeseen treatment.

I consent to treatment after having been advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld or omitted.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is an element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration; and thrombophlebitis (e.g., irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medication or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaw, loss or loosening of dental restorations. Less common complications can include infection, loss, or injury to adjacent teeth and soft tissues, swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risk, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an

exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete of a medical and personal history as possible, including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I will have the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical conditions, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatments and procedures, prior to prescribed treatment.

Financial Consent

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility is always the patients regardless of outside insurance relationship between the carrier and the patient.

Patients without dental insurance must pay for services in full at the time of appointment.

Patients with dental insurance need to understand that billing insurance is only a courtesy we provide, (**ultimately it is the patients', not the office staffs' responsibility to know their insurance coverage**). This office will gladly prepare, submit and attempt to collect and credit any such collection to your account from your insurance company. The patient is then responsible for any balance remaining which shall be due in full. Most dental plans have limitations and restrictions. No insurance policy pays100% of all dental fees. Dental insurance typically does not pay everything and is only meant to be an aid.

I understand that the fee estimate provided for any proposed dental care can only be extended for a period of six months from the date of the patient examination as costs associated with treatment changes regularly. I also agree that the fees provide and/or charged are reasonable.

I authorize treatment of and agree to pay all fees and charges for such treatment. I hereby authorize the release of any pertinent information to my insurance company. I agree that payments will not be delayed or withheld because of any insurance coverage. I acknowledge that all insurance information is accurate and the office of Edward J. Sharkey D.M.D., LLC assumes no responsibility for the collection of any proceeds of insurance. If the information provided is inaccurate and the resubmission of insurance is necessary, I agree to pay 5% of the balance as a resubmission fee.

Default on Payment

If I fail to pay at the time of appointment and if insurance is declined or denied or payment is declined or denied, I agree that I am in default of the payment agreement and subject to the default provisions as outlined herein. Upon default, I agree to pay interest on any balance due at

the rate of 1.5% per month until paid in full regardless of the collection method used. If accounts are placed in collection, whether with an agency or an attorney, I agree to pay all costs and fees associated with collection including fees at the rate of 33.33% of the balance owed which shall include attorneys' fees, plus costs associated with the any action for recovery. I agree these fees are reasonable. The date of default shall be calculated from 60 days of the date of service. I understand that if an insurance claim is denied this office is not responsible for rectifying such denial and is under no obligation to assist the patient in doing so but if this office does assist, it is in no way to be considered a waiver of the costs associated with same. This office will provide one (1) additional copy of the bill to the patient, upon request, without charge, for the patient attempt to resubmit the claim on their own, but this office is under no obligation to wait for the claim to be resubmitted or approved and is not obligated to cease collection activity during the resubmission process. In addition to the amounts owed above in the event of default, I agree that if any checks or negotiable instrument is returned or payment denied or declined in any way for any reason, I will be subject to the statutory maximum fee and collections allowed by law in addition to the collection remedies above. Other than the fees orally quoted, I understand that this agreement may not be modified orally and any change to the conditions of this Agreement must be in writing to be binding.

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Patient or Guardian's Signature Date

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Witness's Signature Date