Statler Orthodontics
7400.W. Camino Real #110
Boca Raton, FL 33433-5513

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize STATLER ORTHODONTICS and JENNIFER T. STATLER, D.M.D. (hereafter collectively referred to as "Practice") to use and disclose the entire medical record in accordance with the Notice of Privacy Practices of

_____.
(PATIENT NAME(S)

I have reviewed the Notice of Privacy Practices, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms.

A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify the Practice, its employees and agents for any and all liability arising out of or occurring under this Consent.

By patient_____
Print name and sign

Date:_____

By parent (representative):_____
Print name, sign and indicate authority relative to patient

Date:_____

STATLER ORTHODONTICS
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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, hereby authorize Statler Orthodontics and Jennifer T. Statler, D.M.D. (hereafter collectively referred to as "Practice") to use and disclose in any form or format a copy of records concerning _____but only as follows.

The Practice may use and disclose the following protected health information, including individually identifiable information, such as names, dates, photographs, x-rays, study models and _____ (identify any other specific data) for the purpose of:

- ☐ Lectures/presentations to dental professionals only
- ☐ Practice marketing; and/or
- ☐ Other: Posting on STATLER ORTHODONTICS business page on Facebook, YouTube and/or bracesandfaces.com website
- ☐ Do Not Display Photo on Social Media

Can we leave a message on your answering machine/voice mail? ☐ Yes ☐ No

People we can discuss your care with _____

_____

_____

This authorization will expire on _____, 20___

You have the right to revoke this Authorization at any time in writing. However, your revocation will not be effective to the extent that this Authorization has been relied on. The information used or disclosed per this Authorization may be subject to re-disclosure by the recipient (s), and thus, no longer protected by the privacy rules.

By patient_____
Print name and sign

Date:_____

By parent (representative): _____
Print name, sign and indicate authority relative to patient

Date:_____ *A copy of this signed, dated Authorization shall be as effective as the original.*

STATLER ORTHODONTICS
ORTHODONTICS * DENTAL-FACIAL ORTHOPEDICS

INFORMED CONSENT REGARDING ORTHODONTIC TREATMENT

Most often, positive orthodontic results are achieved by informed and cooperative patients. However, the American Association of Orthodontists recommends that all who are considering treatment be routinely given the following information. While recognizing the benefits of healthy teeth and a pleasing smile, you should also be aware that orthodontic treatment has some potential limitations and risks. In orthodontics, these are infrequent, and if they do occur, are usually of minor consequence. Nevertheless, they should be mentioned. Orthodontic treatment usually proceeds as planned; however, like all areas of the healing arts, results cannot be guaranteed. Some of the potential areas might be:

Tooth decay, gum disease, permanent markings on the teeth can occur if the patient eats foods containing sugar and does not brush thoroughly and frequently and does not use fluoride as directed. Health of bone and gums could be affected if bacterial plaque is not removed daily with good oral hygiene.

Teeth have a tendency to change positions after treatment, but changes should be very minor if retainers are worn faithfully. Certain causes (not orthodontic) can allow bite to change adversely, such as eruption of wisdom teeth, growth and/or maturational changes, mouth breathing, tongue thrusting, playing of certain musical instruments, and other oral habits. Lifetime retainer wear is recommended to protect your orthodontic result.

Occasionally, problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ), causing joint pain, headaches, or ear problems. These problems may occur with or without orthodontic treatment. Any of the above-noted symptoms should be promptly reported to Dr. Statler.

Patient cooperation can affect results, particularly in wearing of rubber bands, headgear, or any other appliance that depends on patient cooperation in wearing.

In a small percentage of patients, the length of incisor roots may be shortened during orthodontic treatment. Some patients are prone to this happening, most are not. It is nearly impossible to predict susceptibility to this condition.

General medical problems can affect orthodontic treatment. You should keep Dr. Statler informed of any changes in your medical health or in any medications you are taking.

Prior existing dental work could be altered during orthodontic treatment requiring repair or replacement, with cost being patient's responsibility.

Atypical formation of teeth or insufficient or abnormal changes in the growth of the jaws may limit our ability to achieve the desired results. If growth become disproportionate during or after treatment, or a tooth forms very late, the bite may change, requiring additional treatment, or in some cases, oral surgery. Growth disharmony and unusual tooth formations are biological processes beyond the orthodontist's control. Growth changes that occur after orthodontic treatment may alter the quality of treatment results.

In addition to the above mentioned, also specific to your particular diagnosis/treatment plan:

_____

_____

I hereby acknowledge that I have reviewed the above information and have discussed the proposed orthodontic treatment for _____
Print Patient's Name

Signed _____ Date _____
Patient/Guardian

INFORMED CONSENT

I have been given adequate time to read and have read the preceding information describing orthodontic treatment with Invisalign aligners. I understand the benefits, risks, alternatives and inconveniences associated with treatment as well as the option of no treatment. I have been sufficiently informed and have had the opportunity to ask questions and discuss concerns about orthodontic treatment with Invisalign® products with my doctor from whom I intend to receive treatment. I understand that I should only use the Invisalign products after consultation and prescription from an Invisalign trained doctor, and I hereby consent to orthodontic treatment with Invisalign products that have been prescribed by my doctor.

Due to the fact that orthodontics is not an exact science, I acknowledge that my doctor and Align Technology, Inc. ("Align") have not and cannot make any guarantees or assurances concerning the outcome of my treatment. I understand that Align is not a provider of medical, dental or health care services and does not and cannot practice medicine, dentistry or give medical advice. No assurances or guarantees of any kind have been made to me by my doctor or Align, its representatives, successors, assigns, and agents concerning any specific outcome of my treatment.

I authorize my doctor to release my medical records, including, but not be limited to, radiographs (x-rays), reports, charts, medical history, photographs, findings, plaster models, impressions of teeth, or intra-oral scans, prescriptions, diagnosis, medical testing, test results, billing, and other treatment records in my doctor's possession ("Medical Records") (i) to other licensed dentists or orthodontists and organizations employing licensed dentists and orthodontists and to Align, its representatives, employees, successors, assigns, and agents for the purposes of investigating and reviewing my medical history as it pertains to orthodontic treatment with product(s) from Align and (ii) for educational and research purposes.

I understand that use of my Medical Records may result in disclosure of my "individually identifiable health information" as defined by the Health Insurance Portability and Accountability Act ("HIPAA"). I hereby consent to the disclosure(s) as set forth above. I will not, nor shall anyone on my behalf seek legal, equitable or monetary damages or remedies for such disclosure. I acknowledge that use of my Medical Records is without compensation and that I will not nor shall anyone on my behalf have any right of approval, claim of compensation, or seek or obtain legal, equitable or monetary damages or remedies arising out of any use such that comply with the terms of this Consent.

A photostatic copy of this Consent shall be considered as effective and valid as an original. I have read, understand and agree to the terms set forth in this Consent as indicated by my signature below.

Signature

Print Name

Address

City, State, Zip

Date

Witness

Print Name

Signature of Parent/Guardian:

If signatory is under 21, the parent or legal Guardian must also sign to signify agreement.

invisalign

Align Technology, Inc.
(888) 822-5446

STATLER
ORTHODONTICS

"Combining Art & Technology for a Lifetime of Smiles"

Commitment to participate in Good Oral Hygiene Habits

Once you receive your orthodontic appliances, you need to be particularly careful about your oral hygiene/health. Braces provide a great environment for trapping and hiding food particles and make it difficult to brush away plaque, which is the layer of harmful bacteria that attack your teeth and gums. You should be brushing your teeth thoroughly and carefully at least 2-3 times daily.

We recommend that you see your general dentist for regular cleanings (every 3-6 months) and sometimes more often during orthodontic treatment. This is not an option, it is a MUST!

We strongly encourage the use of fluoride rinse or gel daily. This can be used as an additional supplement even if you are brushing with a fluoride toothpaste and getting fluoride treatments topically from your dentist.

MI Paste is recommended to be used twice daily during orthodontic treatment and after treatment is complete. MI Paste guards against plaque build up and harmful bacteria, as well as strengthens tooth enamel. Our office has MI Paste for purchase as it is not sold outside of dental offices.

Please provide our office with your current dentist at all times during your treatment, as we are committed to you to correspond with them throughout your treatment. We are happy to provide you with reminders and tips regarding hygiene while you are in the office, but it is your ultimate responsibility to make sure you are taking care of your/your child's oral hygiene needs by using the above mentioned tools, and making certain that you/they see a dentist regularly.

I, _____, have read the above recommendations, and will take complete responsibility for _____ oral hygiene. I will hold Dr. Statler harmless of any dental issues that arise, due to lack of commitment on our part to participate in the practices of good oral hygiene.

_____ _____

Patient/Parent/Guardian Date

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Federal Truth and Lending Disclosure Statement for Professional Services

FEE

- Covers only professional services performed in this office and one set of retaining appliance
- There is no charge for an active post-treatment period of one year. Any retention visits beyond the one year period will incur a per visit charge.
- No additional charges will be made except for lost or broken appliances, broken appointments, duplication of records, or documented unreasonable lack of patient cooperation.

PAYMENT OF ACCOUNT

- If credit is granted, monthly installments will be due on the first day of each month until the account is paid in full.
- Treatment will be interrupted if the account falls in arrears beyond 45 days.
- Any account in arrears more than 90 days will lead to complete discontinuation of treatment.

TRANSFER

- If treatment is terminated due to transfer or departure, the fee will be recalculated for the appropriate amount due for services rendered and a final adjustment will be made.
- There will be a charge if duplication of records is requested.

INSURANCE

- We will assist you in the filing of the claims and follow-up correspondence to maximize your insurance coverage for orthodontic care.
- We do accept direct payment from most insurance companies. If direct payment is accepted and insurance company does not pay as anticipated, the responsible party agrees to accept full financial responsibility.

Special Instructions:

_____

I hereby certify that I have read and received a copy of the above Federal Truth in Lending Disclosure Statement and have also received a copy and agree to the terms of the attached contract.

□ In-house Financing □ Third Party Financing □ Payment in Full

Dated_____ Responsible Party Signature_____

Patient Coordinator_____