NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect 9/23/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

- **Treatment:** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment for you.
- **Payment:** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management and determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party. For example, we may send claims to your dental health plan containing certain health information.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.
- **Individuals Involved in Your Care or Payment for Your Care:** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health decisions for you, we will treat the patient representative the same way we would treat you with respect to your health information.
- **Disaster Relief:** We may use or disclose your health information to assist in disaster relief efforts.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law.
- **Public Health Activities:** We may disclose your health information for public health activities, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products

or devices; Notify a person who may have been exposed to a disease or condition; Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.
- **Security of HHS:** We will disclose your health information to the Secretary of the U.S Department of Health and Human Services when required to investigate or determine compliance with HIPPA.
- **Worker's Compensation:** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- **Law enforcement:** We may disclose you PHI for law enforcement purposes as permitted by HIPPA, as required by law, or in response to a subpoena or court order.
- **Health Oversight Activities:** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Judicial and Administrative Proceedings:** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
- **Coroners, Medical Examiners and Funeral Directors:** We may release your PHI to a coroner or medical examiner. This may be necessary, for example to identify a deceased person or determine cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.
- **Fundraising:** We may contact you to provide you with information about our sponsored activities, including fundraising programs as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSERS OF PHI: Your authorization is required, with few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS:

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want the copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

  If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

- **Disclosure Accounting:** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.
- **Right to Request a Restriction:** You have the right to request additional restrictions on our use or disclosure of you PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
- **Alternative Communications:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location your request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.
- **Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why denied it and explain your rights.
- **Right to Notification of a Breach:** You will receive notifications of breaches of your unsecured protected health information as required by law.
- **Electronic Notice:** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email)

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternate locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT INFORMATION

Our Privacy Official: Debbie Bank
Telephone: (216) 485-5788
Address: 6700 West Snowville Road. Brecksville, Ohio 44141
Email: dbank@hudecdental.com

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New Patient Registration

Patient Personal Information

Name: _____
Last *First* *MI*

Preferred Name:_____ Social Security #: _____

Date of Birth: _____ Gender: ☐ M ☐ F ☐ _____

Marital Status: ☐ Single ☐ Married

Preferred Contact Method(s): ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Student Status If Dependent Over 19 Years Old (For Insurance):

☐ Full-Time Student ☐ Part-Time Student ☐ Non-Student

How Did You Hear About Hudec Dental? _____

Patient Address & Contact Information

Address Line 1: _____ Address Line 2:_____

City: _____State:_____ Zip:_____ Home Phone:_____

Cell Phone: _____ Work Phone: _____Email: _____

Emergency Contact Information

Emergency Contact 1: _____ Phone:_____ Relationship:_____

Responsible Party Information

If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the next section

Name Of Responsible Party: _____ Date Of Birth: _____

Relationship To Patient: _____ Social Security #: _____

Contact Phone: _____ Address: _____

City: _____ State:_____ Zip:_____ Employer:_____

Insurance Information

Do You Carry Dental Insurance? ☐ Y ☐ N

Primary Dental Insurance

Complete the following with policy holder's information.

Policy Holder's Name: _____ Social Security #: _____

Date Of Birth: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian

Insurance Company: _____

Group Number:_____ Member ID Number: _____

Employer: _____

Secondary Dental Insurance

Complete the following with policy holder's information.

Policy Holder's Name: _____ Social Security #: _____

Date Of Birth: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian

Insurance Company: _____

Group Number:_____ Member ID Number: _____

Employer: _____

To the best of my knowledge, all the information provided above is true.

Patient Signature: _____Date: _____

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Patient Health History

Answers to the following questions are for our records only and will be considered confidential.

Name: _____
Last *First* *MI*

Preferred Name:_____ Date of Birth:_____

Name Of Medical Doctor: _____ Date Of Last Physical Exam: _____

List all medications you are currently taking: _____

_____

_____

Are you allergic to any of the following? *(Check all that apply)*

- ☐ Local Anesthesia
- ☐ NSAIDs *(Ibuprofen, Naproxen, Aspirin)*
- ☐ Codeine
- ☐ Opioids *(Percocet/Oxycodone, Vicodin/Hydrocodone, Morphine)*
- ☐ Metals
- ☐ Other: _____
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin, Amoxicillin, etc.
- ☐ Sulfa
- ☐ Barbiturates

Describe your allergic reaction(s): _____

_____

Do you have any of the following medical conditions? *(Check all that apply)*
**Antibiotics or pre-medication may be required prior to your appointment.*

Cancer: ☐ Y ☐ N If yes, what type?_____

Chemotherapy: ☐ Y ☐ N If yes, when?_____

Radiation Therapy: ☐ Y ☐ N If yes, how many rounds?_____

Cardiovascular

- ☐ Angina (Chest Pain)
- ☐ *Artificial Heart Valve
- ☐ *Heart Murmur
- ☐ Heart Trouble
- ☐ *Congenital Heart Problems
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Scarlet Fever
- ☐ *Rheumatic Fever
- ☐ Stroke
- ☐ *Infective Endocarditis

Respiratory

- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculous
- ☐ Shortness of Breath
- ☐ COPD
- ☐ Persistent Cough

Endocrinology

- ☐ Kidney Disease
- ☐ Liver disease
- ☐ Diabetes
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Thyroid Disease

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Bruise Easily
- ☐ Excessive Bleeding
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Blood Disorders

Viral Infections

- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV
- ☐ Herpes
- ☐ Cold Sores
- ☐ MRSA

Neurological

- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Treatment
- ☐ Migraines/Headaches

Musculoskeletal

- ☐ Arthritis
- ☐ *Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Gastrointestinal

- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease

Other

- ☐ Intellectual Disability
- ☐ * Any type of transplant
- ☐ *Steroid Treatment
- ☐ Use of Tobacco Products
- ☐ Birth Defects
- ☐ Hives of Skin Rash
- ☐ Glaucoma
- ☐ Hay Fever

Additional Medical Information

Have you had Heart Surgery? ☐ Y ☐ N Have you ever been hospitalized? ☐ Y ☐ N

Have you had a transplant operation that has depressed your immune system? ☐ Y ☐ N

Have you ever had any excessive bleeding requiring special treatment? ☐ Y ☐ N

If you use tobacco, what kind and how often/much? _____

If you have had a heart attack, how often do you see a cardiologist? _____

Do you have diabetes? ☐ Y ☐ N If yes, which type? ☐ Type 1 ☐ Type 2

When was your last A1C? _____

What is your Blood Glucose Range? _____ How often do you check it? _____

If you have Hepatitis C, has it been treated? ☐ Y ☐ N

If yes, when did you contract it? _____ When was it treated? _____

If you have sleep apnea, do you use a CPAP machine? ☐ Y ☐ N

Women Only

Are you pregnant? ☐ Y ☐ N If yes, when is the due date? _____

Are you taking oral contraceptives? ☐ Y ☐ N Is there a possibility of pregnancy? ☐ Y ☐ N

Are you currently nursing or breast feeding? ☐ Y ☐ N

Do you have any disease/problems not listed above that we should be aware of? ☐ Y ☐ N

If yes, please describe:_____

_____

_____

Dental History

Reason for today's visit: _____ Are you in pain? ☐ Y ☐ N

Name of previous dentist:_____ Date of last cleaning & exam:_____

Do you have bitewing x-rays that are less than 1 year old? ☐ Y ☐ N

Do you have a panoramic x-ray or full mouth x-rays that are less than 5 years old? ☐ Y ☐ N

How often do you brush your teeth? _____ Floss your teeth?_____

Have you ever had an oral cancer screening? ☐ Y ☐ N

Have you ever been diagnosed or treated for gum/periodontal disease? ☐ Y ☐ N

Do you have sores, lumps or growths in or near your mouth? ☐ Y ☐ N

Do you grind or clench your teeth? ☐ Y ☐ N If yes, do you wear a nightguard? ☐ Y ☐ N

Do you play contact sports? ☐ Y ☐ N If yes, do you wear a mouth guard? ☐ Y ☐ N

Do you currently have any of the following? ☐Swelling ☐Bleeding Gums ☐ Loose Teeth ☐ Bad Breath

Do you have dentures/partials? ☐ Y ☐ N If yes, approximately how old? ☐ Y ☐ N

What would you like to change about your smile? ☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Make Over ☐ Missing Teeth ☐ Whiter Teeth

Have you had an adverse reaction to a dental treatment? ☐ Y ☐ N If yes, what happened? _____

_____

Is there anything related to your dental history that you have not indicated above? ☐ Y ☐ N

If yes, please explain_____

_____

Patient Signature: _____ Date:_____

Doctor Signature: _____ Date:_____

INSURANCE ASSIGNMENT & RELEASE

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Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company PRIOR to any treatment being performed. Please remember your insurance policy is between you and your insurance company.

I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.
I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE CARRIERS.
I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.
I AUTHORIZE MY DOCTOR TO ACT AS AN AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE CARRIERS.
I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR.
I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
I UNDERSTAND THAT EVEN THOUGH THIS OFFICE IS ACTING AS AN AGENT BETWEEN ME AND MY INSURANCE COMPANY, THE INSURANCE POLICY BELONGS TO ME AND I AM RESPONSIBLE FOR WHATEVER THE INSURANCE COMPANY DOES NOT PAY.

I HAVE READ AND AGREE TO ALL OF THE ABOVE (initial) _____

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Hudec Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Hudec Dental to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I also authorize the use of this signature to furnish all medical records pertaining to treatment of patient.

Name (please print) _____ Date _____

Signature _____
(Parent or Guardian must sign if patient is a minor)

Financial Policy Notice and Disclaimer
I acknowledge that I have read, understand, and agree to Hudec Dental's Financial Policy Notice

Patient Initials_____

HIPAA Privacy Sheet
I Acknowledge that I have received a copy of the HIPAA privacy sheet

Patient Initials_____

FINANCIAL POLICY NOTICE AND DISCLAIMER

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At Hudec Dental, we are committed to providing all our patients with the best possible care and service. It's important to us that you have a clear understanding of our financial policies. If you have any questions, please ask any staff member for clarification. Thank you for choosing Hudec Dental.

Personal Payments

Patients are responsible for their charges at the time the service is provided. We accept major credit/debit cards (Visa, Master Card, Discover, Amex) and checks with personal identification.

Patients with Insurance Coverage

Please understand that your insurance coverage is based on a contract between you and your insurance company. The ultimate responsibility for payment always rests with the patient. As a courtesy, we will bill your insurance company for its share of the charges you incur **if current and correct information is provided**. Your share of the bill (your co-pay) is due at the time of service. Please be aware that any bill we send to your insurance company is an estimate only. ***You are ultimately responsible for any portion of your bill not covered by your insurance.*** In the event that your insurance company determines that any service you received is "not covered", you are responsible for the **complete fee**. If your insurance company denies, makes less than full payment, or takes more than 45 days to remit payment, you are responsible for the entire balance.

Financing Options

We are happy to offer our patients, upon application approval, a monthly payment plan through **Care Credit**. There are several interest-free payment plans to choose from and some extended payment plans with small interest rates offered as well. Please feel free to request more information about this option.

Minor Patients and Legal Settlements

Hudec Dental is not party to any legal settlement resulting from a divorce or child support arrangement. Adult patients are responsible for payment at the time service is provided. Responsibility for minors rests with the adult accompanying the patient at the time treatment is provided. Payment for services rendered to a minor is the responsibility of the adult accompanying the patient. A parent or legal guardian should be present to sign a treatment consent form for all patients under the age of 18.

Additional Information

There will be an additional charge of $30 for each invalid or NSF check. Any NSF account remaining unpaid after 10 days will be turned over to collections. Any account remaining unpaid after 30 days may be charged interest at a rate not to exceed that allowed by the state of Ohio. Any account remaining unpaid for over 60 days for which a payment plan has not been arranged or for which scheduled payments are delinquent may be turned over to a collection agency. If an account has been turned over to a collection agency, the patient is responsible for any additional fees incurred in the collection process. In the event a refund is due, payment will be given within 2 weeks after the amount is verified by Hudec Dental. Payment will be rendered in the form in which it was originally submitted (if received in cash, then payment will be rendered in the form of a check). There will be a 5% processing fee deducted for refund requests to issue a check refund for payments initially made with a credit card. Unopened products can be returned in their original packaging within 15 days for a full refund.

CANCELLATION POLICY

We know how valuable your time is and will do our very best to see you at the time of your scheduled appointment. However, if you fail to show up, we could have been providing service to another, equaling deserving patient. **We reserve the right to reschedule your appointment or decrease designated appointment time if you arrive late. A $25.00 "Failed Appointment" fee may be charged if our office is not informed with advance notice of 48 hours or more. If you miss more than 2 appointments without prior notice, we may regrettably have to refer you to another dental practice for your oral care.** Any courtesy discounts are subject to cancellation if you do not comply with Hudec Dental's cancellation policy.

APPOINTMENT AGREEMENT

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Our doctors and hygienists want to be available for your needs and the needs of all patients. When a patient does not show up for a scheduled appointment another patient loses the opportunity to be seen.

Any appointment cancelled within 48 hours, late arrival and/or failing to show up will be considered a broken appointment and a $25 fee may be charged. We reserve the right to reschedule your appointment or decrease appointment time if you arrive late.

If you miss more than three appointments without prior notice, we may regrettably have to refer you to another dental practice for your dental care.

I acknowledge that I have read the above and understand the consequences and my responsibilities.

_____
Name

_____
Signature

_____
Date

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Authorization To Release Information

Last Name: _____ First Name: _____ D.O.B: _____

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and the primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide information for ALL individuals you want us to be able to speak with.

Spouses are NOT automatically included; their names must be explicitly stated below.

You may opt out by checking the "DO NOT Release Information" box below.

Who can information be released to?

Full Name: _____

Relationship:_____

Phone number:_____

What type of information that can be released?

Appointments ☐
Financial Information ☐
Dental Treatment ☐
Insurance ☐
Other: _____

Full Name: _____

Relationship:_____

Phone number:_____

Appointments ☐
Financial Information ☐
Dental Treatment ☐
Insurance ☐
Other: _____

☐ DO NOT Release Information

I hereby authorize the above person(s) to have access to information covered under the Notice of Privacy Practices regarding myself.

Signature:_____ Date:_____

VELscope Oral Cancer Screening Consent Form

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Risk Factors of Oral Cancer that are controllable and un-controllable would be tobacco use, excessive alcohol consumption, using both tobacco and alcohol, excessive unprotected sun exposure, HPV viral infection, race, ethnicity and economics, high risk of cancer recurrence, gender and age.

Signs & Symptoms

Early Indicators are red and/or white discoloration of the soft tissues of the mouth, any sore that does not heal within 14 days, and hoarseness which last for a prolonged period.
Advanced Indicators would be sensation that something is stuck in your throat, numbness in the oral region, difficulty in moving the jaw or tongue, difficulty in swallowing, ear pain that occurs on one side only, being sore under a denture that won't heal, even after adjustment of the denture, or a lump or thickening which develops in the mouth or on the neck.

Oral Cancer Statistics

Each year in the US alone, approximately 34,000 individuals are newly diagnosed with oral cancer. The death rate from oral cancer is very high; about half those diagnosed will not survive more than 5 years. With early detection, survival rates are high, and side effects from treatment are at the lowest.

Get it early. Get it All-VELscope

Our practice believes in early detection of oral cancer. We can now offer you a state-of-the-art cancer exam called the VELscope Oral Cancer Screening System. As always we will continue to provide conventional oral screening exams, however now we are able to do even more!
About the VELscope Exam:

- The exam takes approximately 3-5 minutes
- The exam is comfortable and pain-free
- Completely safe to perform

_____

Patient Name Patient Signature Date

The VELscope peace-of-mind evaluation is available to you for $15.00.

_____ I accept Velscope evaluation

_____ I have read the above information with regards to the potential knowledge available through the VELscope evaluation. At this time I am choosing to decline this form of oral cancer screening.