Enable Dental IN PARTNERSHIP WITH ALIGN SENIOR CARE

Online Registration: https://enabledental.com/alignseniorcare
Email to: bdrecords@enabledental.com
Fax to: (877) 940-4303
Mail to: 5555 N Lamar Blvd, Ste H125, Austin, TX 78751
Questions? Call us at: (866) 988-4504

New Patient Consent Form (Align Senior Care Members)

Enable Dental is partnering with **Align Senior Care** to provide on-site dental care in the comfort of Align Senior Care members' community or personal residence.

Enable Dental provides a full-suite of services including dental exams, low dose x-rays, cleanings (prophylaxis), fluoride treatments, fillings,extractions, crowns, partials, dentures, and much more.

THE FIRST VISIT AND WHAT TO EXPECT

A new patient will receive an initial comprehensive dental exam with an oral cancer screening, x-rays, and cleaning (prophylaxis). A visit summary will be provided after the appointment, which includes treatment recommendations (if applicable) from our licensed dentists. Any treatment recommendations will be communicated and sent via email/mail to the patient or responsible party for approval prior to scheduling for follow-up treatment procedures.

PRICING

Align Senior Care members will receive preventative at no cost to you and treatment procedures at a special discounted rate.

Align Senior Care members are eligible for preventative visits and other dental services dependent on their specific Align Senior Care plan benefits. For more details on benefit coverage, please check the plan benefits documentation for the plan you are enrolled in.

Other dental services such as treatment procedures are covered up to the member's benefit plan annual maximum. The balance of any treatment costs that exceed the plan's maximum benefit will be the responsibility of the patient or responsible party.

LEVEL OF CARE SELECTIONS AND FREQUENCY

Exams	Exams occur every 6 months unless otherwise requested.
Low Dose X-rays	Low dose x-rays are required for all new patients, no exceptions. X-rays are taken every 6 months.
Cleanings (Prophylaxis) →	A dental prophylaxis performed by a dentist or dental hygienist includes scaling and polishing to remove coronal plaque, calculus, and stains. We default to cleanings every 6 months if this field is left blank. ○ Every 6 months ○ No cleanings
Fluoride →	___ Initial here to **opt-in** for fluoride treatments. I wish for the patient to receive fluoride treatments. I understand fluoride treatment may not be covered by my Align Senior Care health plan and I am responsible for any cost outside of coverage for fluoride treatment. ___ Initial here to **opt-out** for fluoride treatments. I **do not** wish for the patient to receive fluoride treatments. * Fluoride treatments are recommended by the American Dental Association and help prevent tooth decay.
Dental Emergency?	☐ Check here if the patient is having a non-life-threatening dental emergency and specify below: ○ Broken tooth ○ Broken/lost dentures ○ Severe pain/swelling ○ Other: ______________

PATIENT INFORMATION

The person filling out this form is the: ○ Patient ○ POA or Responsible Party

First Name ________________________ Last Name ______________________________ Date of Birth ______________

Gender: ○ Male ○ Female Preferred Language: ○ English ○ Spanish ○ Other ________________

Patient Telephone _________________________ Patient Email ___________________________________

The patient currently resides in a: ○ Assisted Living ○ Memory Care ○ Skilled Nursing Facility

Community Name (clarify property if multi-location brand) ____

Community City & State __________________________ Room # __________

☐ I am enclosing a current medication list and face sheet from the community

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ALIGN SENIOR CARE HEALTH PLAN INFORMATION

Align Senior Care members must provide a copy of their membership card and government-issued ID to help avoid errors in billing your insurance company. You may do this by attaching copies of the membership card and ID to this consent form. Please send all documents via fax at (877) 940-4303 or email at bdrecords@enabledental.com.

Insurance Name ______________________ ID # ____________ RXGRP/Plan # ________________

First Name ________________ Last Name ________________ Date of Birth (mm/dd/yyy) ___________

Address ______________________________ City ____________ State ____ Zip ________

DENTAL AND HEALTH HISTORY

Does the patient wear dentures: Complete? ○ Yes ○ No Partial? ○ Yes ○ No

Date of the last dentalexam? ___________ Main reason for dental visit ___________________________

Has the patient had a stroke in the last year? ○ Yes ○ No

Is the patient taking bisphosphonates (osteoporosis medications)? ○ Yes ○ No

Is the patient currently taking prescription blood thinners? ○ Yes ○ No

Does the patient have any artificial heart valves? ○ Yes ○No

Does the patient have any allergies? ○ Yes ○ No

List any allergies here ____

PRIMARY RESPONSIBLE PARTY / MEDICAL POWER OF ATTORNEY (IF APPLICABLE)

First Name ________________ Last Name ______________________ Date of Birth __________

Address __________________________________ City ____________ State ____ Zip ________

Telephone (Home) ________________ Telephone (Cell) ____________________

Email _________________________ Relation to the Patient ________________________

FINANCIAL POWER OF ATTORNEY (IF APPLICABLE AND DIFFERENT FROM ABOVE)

First Name ________________ Last Name ______________________ Date of Birth __________

Address __________________________________ City ____________ State ____ Zip ________

Telephone (Home) ________________ Telephone (Cell) ____________________

Email _________________________ Relation to the Patient ________________________

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FINANCIAL DISCLOSURES

- The patient or responsible party will be responsible for the remaining cost above the member's benefit plan annual maximum.
- The patient or responsible party will required to provide written consent for any treatment and payment information (eg. credit card or ACH) before any treatment visit is scheduled.
- It is the patient or responsible party's responsibility to understand the type of dental insurance they have and the benefits associated with the plan.
- Dental insurance is a contract between the patient and the insurance plan. Benefits will be subject to limitation or benefits maximums available at the time claim is processed.
- Please let us know if you have been seen by another dental provider this year as it will affect your available benefits.
- A 5% late fee will be applied to any outstanding balance not paid within 30 days of services being rendered.
- Checks or ACH payments returned from your financial institution are subject to a $15 processing fee.

AUTHORIZATION AND RELEASE

The patient or their legal representative agrees to the following:

- Enable Dental may review medical records, examine, and provide any necessary dental care:
  - Prior to signing any documents, I have the right to review the following policies of Enable Dental with which I have been provided, read, and fully understood:
    - o General Dental Informed Consent https://enabledental.com/general-dental-informed-consent
    - o HIPAA Notice of Privacy Practices https://enabledental.com/hipaa/
    - o Privacy Policy Terms and Usage* https://enabledental.com/privacy-policy/
  - No guarantee or assurance has been made as to the results that may be obtained through the course of any treatment.
  - Enable Dental is authorized to provide continued care until dental consent is withdrawn, which may be withdrawn at any time.
  - No restorative treatment will be provided without prior written consent.

* We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. You may obtain a copy of our Notice of Privacy Practices at any time by visiting our website, emailing info@enabledental.com, or calling (866) 988-4504. You may reach out to the Privacy Officer Savi Gupta at savi.gupta@enabledental.com.

By signing below, you are acknowledging that:

- You are the patient and make full financial and medical decisions on your own behalf OR you are the Legal Representative with full financial and medical legal decision-making capability.
- You have read and agreed to the General Dental Informed Consent.
- If applicable, you give the care community and Enable Dental explicit consent to exchange patient health information including medical history, medication lists, responsible party information, and other information to ensure the patient's overall care and well being.
- You consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment, and health care operations.
- Teledentistry: You consent to utilizing synchronous (live chat via video) and asynchronous teledentistry (not live). Asynchronous teledentistry utilizes a dental assistant or dental hygienist to collect data and information in-person on behalf of a licensed dentist.This information is sent asynchronously (not live) to the licensed dentist to review and provide recommendations. The results of this exam are then communicated to the patient or responsible party. The dentist may not see the patient in-person. You may request tocommunicate in real-time with the dentist about these findings within 30 days of consult.

SIGNATURES

Patient

Signature: ____ Date: ____________________

(The Patient is the responsible party and can sign for both medical and/or financial decisions)

Power of Attorney

The Patient requires a Medical Power of Attorney (POA) or Guardian

Name: ____ Signature: ____ Date: _____________________

The Patient requires a Financial Power of Attorney (POA) or Conservator

Name: ____ Signature: ____ Date: _____________________