Omerza Orthodontics

Lorain 1740 Cooper Foster Park Rd W, Lorain, OH 44053 · (440) 960-2970

Consents & acknowledgments

Please initial each section · Today's date _____

Patient's name _____ Date of birth _____

1. NOTICE OF PRIVACY PRACTICES

_____ I have been offered a copy of the Omerza Orthodontics Notice of Privacy Practices, which explains how the patient's health information may be used and disclosed and how to get access to it. It is also at lorain-orthodontist.com/forms/.

2. EXAMINATION AND DIAGNOSTIC RECORDS

_____ I consent to an orthodontic examination of the patient by Dr. Frank F. Omerza or the team working under the doctor's direction, and to the diagnostic records the examination may call for: photographs of the face and teeth, dental X-rays, and digital scans or impressions of the teeth. These records are used to diagnose and to plan, and they become part of the patient's chart. The examination does not commit me to treatment. Any treatment is explained first, with its fee and alternatives, and agreed to in writing separately.

3. HOW WE MAY REACH YOU

_____ You may: ☐ leave a voicemail ☐ send appointment reminders by text ☐ email me about appointments and the account. Text and email are not fully secure; we keep them to scheduling and general information unless you ask otherwise.

Besides a parent or guardian, you may discuss the patient's appointments, treatment and account with:

Name _____ Relationship _____ Name _____ Relationship _____

4. PHOTOGRAPHS FOR TEACHING OR PROMOTION

optional, and your care is the same either way

Apart from the diagnostic records in section 2, we sometimes show treatment results or office moments on our website, in our social-media posts, or in teaching. Choose one:

☐ Yes, you may use photographs and video of the patient for those purposes, with the first name only.
☐ Yes, but with no name at all.
☐ No, thank you.

A "yes" can be withdrawn at any time by telling the office in writing; we will stop using the pictures going forward.

5. FEES AND INSURANCE

_____ I understand that the fee for any treatment is quoted in writing before it starts, that it covers the treatment described, and that payment arrangements are agreed before the first appliance is placed. Insurance estimates are estimates: the plan pays what it pays, and the person responsible for the account is responsible for the rest. I authorize the release of the information needed to file claims; the office files them as a courtesy, and whether the plan pays me or the office, the fee remains my responsibility. If a payment is going to be late, I will call the office before it is missed.

Signature of patient (18 or over), or parent or guardian _____ Date _____

Printed name _____ Relationship to patient _____ Witness (office) _____