Website: www.enabledental.com
Email to: info@enabledental.com
Fax to: (866) 815-3719
Mail to: 5555 N Lamar Blvd, Ste H125, Austin, TX 78751
Questions? Call us at: (866) 988-4504

New Patient Consent Form (Texas HCS/ICF)

Enable Dental provides at-home dental services to individuals who are participants of the Home and Community Based Service (HCS) & Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities. We provide dental care at personal residences, group homes, and day-habs. Costs are covered by funding outlined in the individual's IPC for preventive and restorative services for HCS. (HCS participants are fully responsible for all elected services not covered by waiver funding.)

WHAT TO EXPECT AT YOUR VISIT

Enable Dental will perform an initial comprehensive dental examination which includes an oral cancer screening and x-rays, which are required for all new patients for the dentist to determine the patient's dental diagnosis. At this visit, the patient most likely will receive a standard cleaning. In the initial exam the dentist may identify issues which would require a personalized treatment plan and eliminate the standard cleaning. New patients are also offered an optional fluoride treatment.

ADDITIONAL FOLLOW-UP VISITS

Periodic 6 Month Follow-Up Exam Enable Dental patients will receive a periodic exam, oral cancer screening, cleaning (prophylaxis) with fluoride and x-rays which is performed by a dentist or dental hygienist unless otherwise stipulated. Additional follow-up cleanings may occur every 3 months and are based on the recommendations of the dentist. If the dental diagnosis requires additional follow-up and treatment, the dental team will provide an outline of any needed therapy (treatment plan) which will be communicated to the patient or their legal representative via email or first-class mail.

HCS/ICF PROVIDER INFORMATION

HCS/ICF Provider Name: _____

The patient is a participant of: ◯ HCS ◯ ICF ◯ Texas Home Living ◯ Other _____

For HCS or Texas Home Living: Renewal Date_____

Dental Funds Remaining on IPC _____

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

Gender: ◯ Male ◯ Female

The patient currently resides in a: ◯ Group Home/Facility ◯ Personal Residence

Patient's Address _____ City _____ State _____ Zip _____

WHO IS FILLING OUT THE FORM?

The person filling out this form is the: ◯ Patient ◯ POA or Responsible Party ◯ HCS/ICF Provider

RESPONSIBLE PARTY

◯ The patient is their own responsible party who can sign for, and give informed consent regarding medical needs

◯ The Patient requires a Medical Power of Attorney (POA) or Guardian, and this information is provided below

◯ The Patient requires a Financial Power of Attorney (POA) or Conservator, and this information is provided below.

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PRIMARY RESPONSIBLE PARTY (MEDICAL DECISION MAKER/HEALTHCARE GUARDIAN)

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ Telephone (Cell) _____

Email _____ Relation to the Patient _____

SERVICE LOCATION AND CONTACT FOR SCHEDULING

Preferred Dental Service Location:

◯ Day Hab/ Community Center ◯ Group Home ◯ Private Residence ◯ Other_____

Service Location Address _____ City _____ State _____ Zip _____

Contact for Scheduling: First Name _____Last Name _____

Telephone (Home) _____Telephone (Cell) _____

PRIMARY CARE PHYSICIAN

Primary Care Physician / MD: _____ Contact Information: Phone_____

Email address_____

DENTAL HISTORY

Has the patient historically been formally sedated for routine dental exams and cleanings? ◯ Yes ◯ No ◯ Uncertain

Has the patient historically been formally sedated for needed dental treatment? ◯ Yes ◯ No ◯ Uncertain

Does the patient wear dentures (complete or partials)? ◯ Yes ◯ No

Date of the last dental exam? _____ Main concern for dental visit _____

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:
        - General Dental Informed Consent https://enabledental.com/general-dental-informed-consent-2/,
        - HIPAA Notice of Privacy Practices https://enabledental.com/hipaa/
        - 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.
    - If applicable, you give the care community explicit consent to share patient health information (medical history, medication lists, responsible party information) with us as the patient's healthcare provider. You also allow Enable Dental to send patient information, notes, and post-op information to the care community to facilitate continuity of the patient's overall care and well- being.
- By signing this document, you acknowledge that you are either the patient or responsible party with medical decision-making capabilities and responsibilities for the patient.

SIGNATURE

Name: _____

Signature: _____ Date: _____

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PRICING

New Patient Visit

- Comprehensive exam and cancer screening $124
- Low dose X-rays* $159
- Prophylaxis cleaning** $152
- Fluoride treatment $57

*Note: Denture check may need to include X-rays
**Cleaning is subject to dental diagnosis and will reduce the price by $152 if not provided

Optional Services

◯ **I do not** wish for the patient to receive the initial fluoride treatment. I understand fluoride treatments are recommended by the American Dental Association and help prevent tooth decay.

BILLING CONTACT (WHO WE SEND BILLS TO)

◯ Send Bill to Corporate Office ◯ Send Bill to Local Office

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ Telephone (Cell) _____

Email _____ Relation to the Patient _____

All payments are due within 60 days from the date of service. Failure to pay invoices within 60 days may result in the company being reported to both the Texas Auditor's Office and the Texas Health and Human Services Office of the Inspector General.

FINANCIAL DISCLOSURES

- We are not a contracted provider for Medicare or Medicaid
- Home and Community Based Services (HCS)
  - As a HCS recipient, all services are paid for by the HCS program provider up to the amount listed on the patient's IPC funds. Any services rendered that exceed the amount listed on the patient's IPC funds will be the responsibility of the patient.
- Intermediate Care Facilities (ICF)
  - As an ICF recipient, all services are paid for by the ICF program provider up to the approved amount authorized by the ICF program provider. The patient and/or guardian are not responsible for any financial expenses.

All pricing is subject to change except situations governed by an active contract.

SIGNATURE

Name: _____

Signature: _____ Date: _____