Jeffrey I. Goldberg DDS PLLC

FACIAL PAIN & APNEA APPLIANCE THERAPY

REQUIRED DOCUMENTATION

JEFFREY I. GOLDBERG DDS PLLC

Patient:_______________________________________

Legal Guardian, if applicable: _____________________

Date:____________________

SECTION #1: NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reasons we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth, mouth, and oral health; prescribing medications and faxing them to a pharmacy; prescribing dental appliances and dental prostheses; showing you treatment options; referring you to another dentist for specialty care; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your dental or medical care plans, or other sources of payment; preparing and sending bills or insurance claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission. We will not disclose your personal or health information for marketing or fundraising purposes.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

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- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home, or by text message or e-mail.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to Dr. Goldberg or Rachel Bender at the office.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. We must honor a restriction not to send information to a health care plan regarding any service for which you have already made full payment. To ask for a restriction, send a written request to Dr. Goldberg or Rachel Bender at the office.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you

want to ask for confidential communications, send a written request to Dr. Goldberg or Rachel Bender at the office.

- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 10 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get photocopies of your health information, send a written request to Dr. Goldberg or Rachel Bender at the office.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment to Dr. Goldberg or Rachel Bender at the office.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to Dr. Goldberg or Rachel Bender at the office.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the to Dr. Goldberg or Rachel Bender at the office.
- be notified by us in a timely manner of any breach of the privacy and confidentiality of your unsecured protected health information, which we will provide to you in accordance with law and take all appropriate measures to address.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to Dr. Goldberg or Rachel Bender at the office. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices for Jeffrey I. Goldberg DDS PLLC.

Signature ____ Date _____________________

SECTION #2: HIPAA AUTHORIZATION, PART 1

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize Jeffrey I. Goldberg DDS PLLC to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s) or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Signature ____ Date _____________________

SECTION #3: HIPAA AUTHORIZATION, PART 2

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgement in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom

we may discuss your medical or payment information under our group health plans.

☐ The practice may communicate with any of the doctors and other health care providers whom I have indicated are currently involved in treating my present condition

☐ The practice may communicate with my spouse or significant other relating to my medical or payment information

☐ The practice may communicate with the following additional individuals relating to my medical or payment information:__________________________
____

☐ The practice MAY NOT communicate with the following individuals relating to my medical or payment information: ______________________
____

Signature ______________________________________ Date ____________________

SECTION #4: FINANCIAL POLICY

Our first commitment is to provide you with the highest quality dental care. As providers of medical care, our relationship is with you, not with your insurance company or any other third party. Ultimately, financial responsibility for care rests with the patient or responsible associate. Payments are due at the time of service unless other arrangements have been approved in advance by Dr. Goldberg and the staff. If you have medical or dental insurance, we would like to help you receive your maximum allowable benefits. As a courtesy, we will help you process your insurance paper-work for your reimbursement, or process it on your behalf. Reimbursements are typically sent directly to the patient, but may, in some cases, be assigned to the practice by the patient. While our staff is very experienced in insurance matters and is committed to helping you, please understand that we do not represent the insurance companies and cannot guarantee their cooperation, nor can we assume an unreasonable burden to negotiate with insurance companies on your behalf.

We accept cash, checks, and most major credit cards. We are also able to offer incremental payment arrangements with interest-free financing up to one year. Financing is handled by CareCredit or Springstone and requires approval of a credit application. Any contract entered into with a credit agency is independent of the practice.

The financial policies of an insurance company may, at times, differ from the standard policies of the practice. For example, an insurance company may allow a fee for a follow up visit or an appliance repair which the practice might not otherwise charge for. When an insurance company is paying any portion of the fees associated with treatment, the practice will adhere to the guidelines set forth by that insurance company, so long as they do not compromise ethical or professional standards. Therefore, in such cases as the previous example, the allowed fee would be

charged, and you the patient would be responsible for any co-pay, as dictated by the agreement we each have with the insurance company.

At the present time, Dr. Goldberg is a participating provider with a small number of medical insurance companies for the treatment of sleep apnea and orofacial pain. Fees and coverage for patients with these insurances will vary by contract, and we will help clarify those details when planning treatment. For general dentistry, Dr. Goldberg is also a participant with certain dental insurance plans. For all other insurance plans, his care will be considered “out of network.” In such circumstances, if your policy has both an "in network" and "out of network" provision, you are reimbursed at the out-of-network rate for our services. Before your appointment, you may wish to check with your insurance company to ensure you have out-of-network benefits, as some plans do not offer this option.

Insurance companies may require pre-authorization for certain procedures. This process is initiated by the practice and is typically completed prior to treatment. Pre-authorization may not be a guarantee of coverage, as insurance company policies are subject to change.

For those patients with two or more insurance plans, we do not typically handle billing other than for the primary insurance. As always, we will do our best to help you submit for additional reimbursement and will provide the necessary bills, receipts and other paperwork.

Balances older than ninety (90) days will be subject to interest of 1% per month. There will be a $25 fee for returned checks. We reserve the right to apply a $20 rebilling fee and $25.00 late charges toward overdue financial agreements. We have the option to report your balance with us to any credit reporting agency and credit bureau. In the event that your account is turned over to a collection agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees. The current collection fee is $15. Information you provide may be used for identification purposes in collections proceedings, including insurance information.

Please note that there is a fee of $65.00 (subject to change) for all missed appointments not given at least 24 hours notice. Please give us a call in advance if you need to reschedule or cancel your appointment. A written request is necessary if you would like us to duplicate any part of your records. We require at least 8 working hours to prepare your records to be transferred. We require at least 3 business days if your record is more than two years old and is stored in a company archive. The cost of duplicated or printed x-rays is $5.00 for a single x-ray, $25.00 for a full mouth x-ray series and $25.00 for a panoramic x-ray. Document copying and printing fees are $1.00 per page. There is a $5.00 fee to e-mail x-rays or send them by similar electronic transmission. These fees do not apply to records and x-rays provided to specialists at our referral.

Dr. Goldberg does not give refunds for any care which has been completed. With any medical or dental procedure, there can be no guarantee of success, and untoward side effects and complications are possible for which the doctor is not responsible. In the case of an oral appliance or dental prosthetics, once lab work has begun on the product the patient is responsible for associated fees. Any disagreements concerning fees or outcomes, if not resolved with the practice directly, may be brought to the attention of the local or state dental regulatory agencies, for which Dr. Goldberg can provide contact information.

If you have any questions regarding this information or any uncertainty about insurance coverage, please do not hesitate to ask. Dr. Goldberg's staff is very knowledgeable about these matters and will do our best to help our patients.

This is an agreement between Jeffrey I. Goldberg DDS PLLC, as a provider of professional services and creditor, and the patient/debtor named on this form. By reading and signing this agreement, you are agreeing and accepting this policy in full.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION; I UNDERSTAND AND AGREE TO THE FINANCIAL POLICIES OF JEFFREY I. GOLDBERG DDS PLLC.

Signature ______________________________________ Date ____________________

SECTION #5: CONSENT FOR TREATMENT

I herby authorize Dr. Jeffrey Goldberg DDS MS MBA and his trained and supervised assistants, to perform upon me those dental procedures which we discuss and which I accept. I consent to the treatment plan I have accepted after having been advised of alternate plans of treatment available. If any unforeseen condition arises in the course of these designated procedures calling, in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize whatever he/she deems advisable.
I am informed and fully understand that there are certain risks in preventive, restorative and surgical dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post operative pain and throbbing, swelling and infection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings. The most common of these complications in oral surgery include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, and loss or loosening of dental restorations. Other less common complications include, but are not limited to: infection, loss or injury to adjacent teeth and soft tissues, jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, nerve disturbances (e.g. numbness in mouth and lip tissues), and small root fragments remaining in the jaw which might require extensive surgery for removal. These complications may be temporary or permanent.
I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reaction), cardiac arrest, thrombophlebitis, (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs. A more complete explanation of all complications is available to me upon my request from the Doctor.
I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.
If you have children who are patients here, please read below:
We would be appreciative if the parent, legal guardian, or other appropriate representative (grandparent, babysitter, older sibling) stay with the minor for the duration of the visit. For the child's safety, we do not allow a minor under the age of 18 to be left alone for their appointments unless we have established a clear understanding with the parent or guardian and have a dependable method of contacting that person. Please note that the person who arrives with the minor, regardless of custody or legal status, is also responsible for that child's financial obligation and care for that day.

DETAILS SPECIFIC TO ORAL APPLIANCE THERAPY FOR SLEEP APNEA:

Oral Appliance Therapy (OAT) is a treatment option for obstructive sleep apnea and snoring. Dr. Jeffrey Goldberg, a member of the American Academy of Dental Sleep Medicine trained in the provision of this service, is committed to delivering your care to the standards of the profession and with a sincere interest in your total well being.
Like all medical interventions, OAT is not guaranteed to work and success depends primarily on the patient. To ensure the best possible result, the oral appliance must be used every night, or as otherwise directed by the doctor. The appliance must be cleaned routinely and adjusted when necessary. It is imperative that you attend appointments as directed. <u>In signing this consent, you are committing to use the appliance as directed, maintain it properly, and attend all necessary appointments</u>.
A sleep study (polysomnography) and diagnosis is required before the initiation of OAT. In many cases, a second study is required to assess the efficacy of the treatment. <u>In signing this consent, you are indicating that you</u>

understand that a sleep study is the only reliable method to determine if OAT is producing objective improvements in your sleep condition, and agree to have a second sleep study if indicated.
Patients seeking treatment for snoring must have a sleep study to rule out sleep apnea prior to treatment. It is dangerous to treat the snoring symptom without testing for and monitoring the underlying cause.
Side effects of OAT include the following:

- Pain / soreness in jaws, temporomandibular joint (TMJ), teeth, gums, tongue or throat. This is often a temporary condition, lasting only minutes after removing the appliance and only for the first weeks or months of treatment. However, more significant or longer lasting discomfort are possible.
- Increased salivation or dry mouth. This is typically present only during the first few nights of appliance use.
- Misaligned bite sensation. Patients often feel that their bite is "off" when first removing their appliance in the morning. This is typically caused by the muscles controlling the jaw returning to their regular position. It is a sensation that typically lasts only a short time (less than an hour) and can be lessened by massaging the muscles. A "morning deprogrammer" appliance is provided to help re-align the jaw muscles in the morning and should be used as directed.
- Movement of teeth, development of spaces between teeth, changes to the bite or alignment of the upper and lower jaws, and damage to existing dental work. With wear, it is possible that your bite will change in a noticeable way. Research shows that movement of teeth with OAT is rare and usually so slight as to be unnoticeable. Damage to sound dental work is very rare. However, it is possible to experience these changes and dental restoration may be necessary as a result.

While there are potential side effects to Oral Appliance Therapy, they must be weighed against the risk of leaving the condition untreated. Obstructive Sleep Apnea and sleep deprivation are dangerous, even life-threatening conditions, which should be treated in spite of any minor risks presented by that treatment. In signing this consent, you are indicating that you are aware of these risks.

Research indicates that OAT is more effective in mild and moderate sleep apnea than severe. OAT is also more effective in women than men. Patients with supine-dependent apnea tend to see greater improvement with OAT as well. Weight loss can greatly improve the sleep apnea condition and the success of OAT. Conversely, weight gain can have a negative effect on the condition and therapy. In signing this consent, you are indicating that you are aware of these conditions which may affect your therapy. You are also promising to provide Dr. Goldberg with complete and accurate information and to inform him of any significant changes in your health.
Dr. Goldberg charges a standard fee ($2400, subject to change) for OAT, for which the patient is ultimately responsible. The fee may vary with conditions of treatment and certain insurances, which the patient will be made aware of. Payment is due at the time of examination, prior to delivery of the appliance. The fee covers the appliance and all follow-up appointments and adjustments with Dr. Goldberg for six months (as discussed in the financial policy, this may vary with insurance companies, as some plans do involve billing for follow up visits within this period). The replacement cost for an appliance that is lost or damaged within one year is $750 (subject to change). In many cases, medical insurance will assist with the fee. Dr. Goldberg and his staff will attempt to determine your medical coverage for this therapy and to help you obtain it. However, the practice is not responsible for decisions made by insurance companies and does not guarantee their payment. Collection of fees is subject to the policies outlined in the standard Financial Policy for Jeffrey I. Goldberg DDS PLLC.
In the event that you are uncomfortable with your appliance, do not experience the desired results, or have negative side effects, Dr. Goldberg will make every reasonable effort to address those issues and achieve a positive outcome. If indicated, Dr. Goldberg will replace the appliance with a new one, perhaps of a different design. If problems persist beyond the one time replacement and reasonable efforts at adjustment, it may be necessary to discontinue oral appliance therapy. The practice will not refund any fees, including co-payments, in the event of an unsuccessful course of treatment. In signing this consent, you are indicating that you are aware of the cost of care and are ultimately responsible for paying the fees incurred, with or without the support of your medical insurance company.

DETAILS SPECIFIC TO FACIAL PAIN THERAPY:

In the treatment of facial pain and headaches, Dr. Goldberg typically relies on a multi-factorial approach involving multiple treatment modalities. Some of the frequently used treatments include injection therapy, medications, iontophoresis, ultrasound and cold laser, in addition to oral appliances and physical therapy and exercises. Any

modality involving medications, including iontophoresis and injection therapy, carries a risk of allergy or undesirable reaction. Dr. Goldberg will carefully consider these risks and will discuss them with you as appropriate for any medications utilized. It is critically important to provide Dr. Goldberg with a complete and accurate medical history to minimize these risks. Iontophoresis and injections may also cause tenderness, swelling, discomfort, or discoloration at the site of application. Ultrasound and cold laser are known to carry few risks. It is possible that you may experience painful heat or dizziness or nausea during or after treatment.
Oral appliances (sometimes referred to as occlusal guards, splints, or night guards) are often used in the treatment of various facial pain conditions, including TMJ disorders (TMD), to relieve tension in the temporomandibular joints and surrounding muscles. Dr. Goldberg can determine the appropriate appliance for your care, and it will be fabricated to his high professional standards. In many cases, more than one appliance may be used to achieve the desired relief, or it may be necessary to change from one appliance to another in the course of treatment.
Like all medical interventions, oral appliances are not guaranteed to work and success depends primarily on the patient. To ensure the best possible result, the oral appliance must be used as directed by the doctor. The appliance must be cleaned routinely and adjusted when necessary. It is imperative that you attend appointments as directed. In signing this consent, you are committing to use the appliance as directed, maintain it properly, and attend all necessary appointments.
Side effects of appliance therapy can include the following:

- Pain / soreness in jaws, temporomandibular joint (TMJ), teeth, gums, tongue or throat. While the goal is to relieve pain in the TMJ area, in some cases the body does not respond as expected. This may be a temporary condition, lasting only minutes after removing the appliance and only for the first weeks or months of treatment. However, more significant or longer lasting discomfort are possible.
- Increased salivation or dry mouth. This is typically present only during the first few nights of appliance use.
- Misaligned bite sensation. Patients often feel that their bite is “off” when removing their appliance. This is typically caused by the muscles controlling the jaw returning to their regular position. It is a sensation that typically lasts only a short time (less than an hour) and can be lessened by massaging the muscles.
- Movement of teeth, development of spaces between teeth, and damage to existing dental work. With use, it is possible that your bite will change in a noticeable way. In some cases, orthodontics or dental restorations are indicated to align the teeth in this new bite position. Damage to sound dental work is very rare. However, it is possible to experience these changes and repairs may be necessary as a result.

While there are potential side effects to appliance therapy, they must be weighed against the risk of leaving the condition untreated. Facial pain is often a progressive condition, with continuing pain or dysfunction which may become worse without intervention. In signing this consent, you are indicating that you are aware of these risks.

Oral appliances are only intended to serve as part of your therapy for facial pain, and you are unlikely to achieve optimum results relying on the appliance alone. A complete course of care will typically include exercises, relaxation techniques, behavioral changes, and so on as presented by Dr. Goldberg and his team. You may also be referred to a physical therapist, psychologist, or other professional. Medical conditions such as fibromyalgia, depression, and arthritis can also contribute substantially to facial pain or present challenges in the treatment, and so should be addressed by the appropriate medical care. In signing this consent, you are indicating that you are aware that the treatment of facial pain requires a comprehensive, multi-factorial approach. You are also promising to provide Dr. Goldberg with complete and accurate information and to inform him of any significant changes in your health.

The fees associated with the oral appliance component of your therapy will depend on the type of appliance(s) used, and the patient is ultimately responsible. Payment is due prior to delivery of the appliance. The fee covers the appliance and all follow-up appointments and adjustments with Dr. Goldberg for 6 months (as discussed in the financial policy, this may vary with insurance companies, as some plans do involve billing for follow up visits within this period). There is a replacement or repair cost for an appliance that is lost or damaged. Collection of fees is subject to the policies outlined in the standard Financial Policy for Jeffrey I. Goldberg DDS PLLC.

Jeffrey I. Goldberg DDS PLLC
FACIAL PAIN & APNEA APPLIANCE THERAPY

In the event that you are uncomfortable with your appliance, do not experience the desired results, or have negative side effects, Dr. Goldberg will make every reasonable effort to address those issues and achieve a positive outcome. If indicated, Dr. Goldberg will replace the appliance with a new one of a different design. The practice will not refund any fees, including co-payments, in the event of an unsuccessful course of treatment. <u>In signing this consent, you are indicating that you are aware of the cost of care and are ultimately responsible for paying the fees incurred, with or without the support of your medical or dental insurance company</u>.

Signature ______________________________________ Date ____________________

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