A Personal Message from Jordan J. Balvich, DMD, PC

Thank you for considering a partnership with us in caring for your dental, oral, and airway health. We understand that choosing the right provider for your well-being is an important decision, and we truly value your trust. This is a significant commitment, so we want to share some foundational beliefs and expectations to ensure we're aligned before moving forward.

1. Doctor-Patient Relationship

We believe that a doctor-patient relationship is built on trust, dedication, and respect. Working together means committing to a path that promotes not only oral health but also the impact that proper dental and airway health can have on your overall well-being. While we don't require a binding contract, we value our relationship as one based on mutual understanding. Should the relationship ever feel unbalanced or unrewarding, we can revisit our agreement to ensure it remains fair and supportive of your health goals.

2. Commitment to Quality Dental and Airway Care

We offer high-quality, personalized care to a limited number of patients, allowing us to fully invest in your unique needs. Your results will reflect the commitment and effort you put into achieving optimal dental, oral, and airway health. Our role is to guide, support, and educate, but lasting health improvements will depend largely on your dedication to maintaining and prioritizing your care.

3. Financial Considerations and Fair Exchange

Quality dental and airway care should be accessible to those genuinely committed to their health. For those facing financial hardship, we offer options for payment assistance.

4. Value of Time and Energy

We are deeply committed to each patient's journey toward optimal dental, oral, and airway health, while also dedicating time to our families. To ensure efficient and meaningful care, we ask that you choose a care plan that best supports your needs, and make a list of questions or requests to discuss during appointments. I encourage you to keep us updated on your progress, as we are invested in seeing improvements in your health. Some issues may require a phone call rather than a text, and there may be charges for extended communications outside scheduled appointments.

5. Long-Term Commitment to Health

We recognize that we may not be the ideal provider for everyone and respect those seeking the right practitioner. We value long-term relationships with this practice members and prefer to avoid a "quick-fix" approach to care, as lasting changes in dental, oral, and airway health require consistent effort and time. We understand that life can change plans, and we remain flexible to adapt if things shift after you've committed to a plan.

Thank you for taking the time to understand our approach. If this resonates with you, we look forward to working together on your journey to better dental, oral, and airway health.

INTENT OF TREATMENT

_______ I understand that my body is a self-healing and self-regulating organism, whose natural state is hardwired for health, healing, and life. I believe my body has the ability and potential to heal, and this is what I desire for myself. I am seeking the assistance of Jordan J. Balvich, DMD, PC, to help facilitate this healing in the context of my dental, oral, and airway health. I understand it is not the responsibility of Dr. Balvich to “heal me” but to help reconnect me with the innate intelligence within me.

_______ I understand that the full intention of Dr. Balvich and/or Jordan J. Balvich, DMD, PC, is to support my health and never to do harm.

_______ I understand that, with any dental or healthcare procedure, there may be risks of negative reactions or side effects. If any such reactions occur, I will notify Dr. Balvich immediately.

_______ I understand that, in order to follow my treatment plan appropriately, I must keep up with follow-up visits and consultations to evaluate and monitor my progress and make any necessary adjustments. Some products and procedures may be designed for short-term use, while others may be long-term; I understand it is my responsibility to keep Dr. Balvich informed of my care through routine visits at intervals that we both agree upon.

_______ I understand that information shared between Dr. Balvich, his staff, assistants, and myself (and, if applicable, my children, spouse, or other approved parties) is confidential. If visits or phone calls are recorded, all parties will be notified and give their approval. Any recordings, treatment plans, and customized recommendations received by me will not be shared with others, posted online or on social media, or disclosed to other parties without Jordan J Balvich, DMD, PC consent.

______ I understand that if I ever feel dissatisfied with my care or experience at **Jordan J. Balvich, DMD, PC**, I am encouraged to reach out directly to Dr. Balvich or his team. I believe open communication is key to addressing concerns and finding solutions together. By notifying the practice first, I can ensure my concerns are heard and resolved in a way that supports my treatment goals.

Patient Signature: ____ **Date:** ____________________

Signature of Dr. Balvich: _______________________________________ **Date:** ____________________

COMMUNICATION AUTHORIZATION

For Private Use of Email, Phone, and Text

To enhance communication with our patients, *Jordan J. Balvich, DMD, PC* may use email, text, and voicemail for non-urgent messages. These communications may include, but are not limited to:

- Appointment confirmations and scheduling
- General questions and responses

- Invoicing and billing information
- Communication with mutual healthcare providers
- Release of medical information and test results

While these communication methods are convenient, transmitting patient information via email, text, or voicemail (“E-Messages”) involves risks, which include:

- E-Messages may be circulated, forwarded, or stored in paper or electronic files.
- E-Messages may be misaddressed or sent to unintended recipients.
- E-Messages are more susceptible to falsification compared to written or signed documents.
- Backup copies may exist even after deletion.
- Employers or online services may archive and inspect E-Messages.
- E-Messages can be intercepted, altered, or used without authorization.
- E-Messages may introduce viruses into systems.

Jordan J. Balvich, DMD, PC will take reasonable precautions to protect the confidentiality and security of your information. However, absolute security cannot be guaranteed, and the practice cannot be held liable for unintended breaches not caused by intentional misconduct.

Patient Consent Conditions

By consenting to E-Messages, you agree to the following conditions:

- Communications concerning diagnosis or treatment may be forwarded internally to authorized staff as necessary and included in the patient’s medical record.
- E-Messages will not be used for medical emergencies or urgent matters requiring immediate response.
- It is the patient’s responsibility to follow up on any E-Message requiring a response if no reply is received within a reasonable time.
- Sensitive medical information (e.g., mental health, STDs, or substance abuse) should not be communicated via E-Messages.
- The patient is responsible for securing their email and phone access (e.g., passwords).
- *Jordan J. Balvich, DMD, PC* will not engage in unlawful communications (e.g., practicing across state lines).

Patient Authorization

Please initial below to indicate your agreement and acceptance:

E-MAIL:
I authorize *Jordan J. Balvich, DMD, PC* to use email to contact me or other professionals involved in my care. I understand this practice does not use specialized encryption for email, and I agree to release the practice from liability for unintended breaches of confidentiality.

- Authorized email address: ____
- Authorized email address: ____

VOICEMAIL:
I authorize *Jordan J. Balvich, DMD, PC* to leave detailed clinical information on my voicemail, including appointment details, health information, test results, or treatment recommendations.

TEXT MESSAGES:
I authorize *Jordan J. Balvich, DMD, PC* to send clinical information to my mobile device, including appointment details, health information, test results, or treatment recommendations.

- Authorized mobile number(s): ____

Acknowledgment

I have read and fully understand this consent form. I understand the risks associated with communication via email, text, or voicemail and authorize the practice to communicate with me using these methods.

Patient Name: ____
Date: ______________________

Signature of Patient, Parent, or Legal Guardian: ____________________________
Signature of Witness: ____
Date: ______________________

1. Payment Expectations

To ensure the smooth operation of your practice and provide you with the highest level of care, we ask that all patients adhere to the following payment expectations:

- **Payment Due at Time of Service:**
  - All payments are due in full at the time services are rendered unless prior arrangements have been made.
  - Payment at the time of service helps us maintain affordable care for all patients.
- **Cash or Check Savings:**

    - A 3% savings is offered for payments made with cash or check.

- **Payment Plans:**
    - Many of our patients choose to work with Sunbit, Alpheon, and CareCredit for their low monthly payment options.
    - We also offer a" Lay-A-Way" program.

Our Commitment to Your Care—Navigating Insurance Together

At **Jordan J. Balvich, DMD, PC**, we want you to know that our practice is dedicated to working **solely for you—not for any insurance company.** While most insurance plans offer valuable benefits, our focus is on helping you **maximize those benefits** to best support your health.

Many patients find it helpful to think of their dental insurance like a **coupon in the Sunday paper**—it may cover certain services, but rarely at 100%. It's important to remember that your coverage is often selected by your **employer**, which means it may not fully align with your specific needs. Still, **something is better than nothing, and we're here to help you make the most of it.**

Our care recommendations and fees are based entirely on **your individual needs**, not on insurance limitations. While we are happy to assist by submitting claims on your behalf, **insurance companies do not always make this easy.** In some cases, the **extraordinary amount of time and effort** required to manage certain claims goes beyond what is typically covered. When this occurs, the additional administrative time spent advocating for your benefits may result in a **processing fee**, which will be the patient's responsibility.

Ultimately, **we are here to provide care for you.** Our goal is to ensure you receive the **best possible treatment** without unnecessary delays or compromises. If you have any questions about your coverage or how we handle insurance, we're happy to guide you through the process.

◈ **We work for you, not the insurance companies.**
◈ **We base our care on your needs, not insurance restrictions.**
◈ **Any portion not covered by your plan is your responsibility.**

Your health comes first, and we're honored to be your partner in achieving the best care possible!

Signature ______________________

Date __________________________

Lab Case Payment Policy

To ensure the timely completion and delivery of your lab case, **all lab cases must be paid in full before they are completed or delivered.**

If you have insurance, please be aware that **delays in payment from your insurance provider can lead to delays in your treatment.** To prevent this, we strongly encourage patients to pay in full at the time of service and seek reimbursement directly from their insurance plan.

Additionally, if **extra treatment is required** due to a delay in payment or if your case requires **specialized attention beyond standard care**, an **"Extraordinary Care" fee** may apply. This fee is not covered by insurance and will be the patient's responsibility.

We appreciate your understanding and cooperation as we work to provide you with the highest quality care without unnecessary delays. If you have any questions, please don't hesitate to ask.

Broken Reservation Routine

- **Advance Notice Requirement:**
  All reservations require at least 48 hours or 2 business days' notice for cancellations or rescheduling to avoid a fee.
- **Fees for Broken Reservations:**
  Reservations canceled or rescheduled with less than 48 hours or 2 business days' notice may incur a fee up to but not to exceed the full cost of the reserved service.
  As a trade-off for accepting many discounted and traditional dental plans, we unfortunately must apply this routine. If a deposit was placed for the reservation, it will be forfeited in the event of a short-notice cancelation or no-show. These additional fees are subject to collections if not paid in a timely manner.
- **Communication:**

  Within the 48-hour window, cancellations or rescheduling requests must be made **by phone only**. Please call our office at **219-866-8110.** Text messages or other forms of communication will not be accepted for changes during this period.

We appreciate your understanding and cooperation in helping us maintain an efficient schedule for all our patients.

Please Initial ______

Social Media Release Form

Patient Name: ___________________________________
Date of Birth: ___________________________________

We are excited to share the progress and successes of our patients on our social media platforms and website. By signing this form, you grant us permission to use your photos, videos, and/or testimonials for marketing and educational purposes. Please read the following information carefully and let us know if you have any questions.

1. Authorization

I, the undersigned, hereby authorize **Jordan J. Balvich, DMD, PC** to use, publish, and display my images, videos, and testimonials, including any identifying information related to my treatment, on the following platforms (check all that apply):

- ☐ Facebook
- ☐ Instagram
- ☐ Website
- ☐ Other ___________________________

2. Consent to Share Treatment Progress and Testimonials

I understand that my images and testimonials may be used in:

- Social media posts highlighting treatment progress
- Educational content for prospective patients
- Marketing materials for **Jordan J. Balvich, DMD, PC**
- Any other purpose related to promoting services and patient care

3. Release and Waiver

I hereby release **Jordan J. Balvich, DMD, PC**, its employees, and agents from any and all claims, liabilities, or damages arising from the use of my images, videos, and testimonials as described above. I understand that I will not receive any compensation for the use of these materials.

4. Confidentiality

I understand that any personal information not directly related to my dental care or treatment will remain confidential and will not be shared publicly.

5. Revocation

I understand that I may revoke this authorization at any time by providing a written request to **Jordan J. Balvich, DMD, PC**. However, I understand that revocation will not affect any actions taken before the receipt of my written revocation.

Please select one of the following options:

- ☐ I consent to the use of my images, videos, and testimonials as outlined above.
- ☐ I do not consent to the use of my images, videos, or testimonials.

Signature: _______________________________
Date: ___________________________________

Parent/Guardian Signature (if under 18): ___________________________________
Date: ___________________________________

Practice Representative Signature: ___________________________________
Date: ___________________________________