



McDuffie

In-Home Dental Care

Mobile Dental Services Consent, Safety Expectations & Financial Terms

PATIENT CONSENT

I authorize Dr. Jamel McDuffie and team members to provide mobile dental evaluation and treatment in my residence. I understand some procedures or emergencies may require referral to a traditional dental office or hospital.

HOME SAFETY REQUIREMENTS

I agree to provide a safe, well-lit workspace, secure pets, disclose occupants, and ensure pathways are hazard-free. Respectful conduct is required at all times.

RIGHT TO TERMINATE SERVICES

Provider may terminate visits immediately if safety risks arise. Charges may still apply if visits are ended due to unsafe conditions, misrepresentation, or failure to comply with safety expectations.

MOBILE CARE LIMITATIONS

I acknowledge that home-based care may have limitations compared to an equipped dental office and further treatment may be required elsewhere.

PRIVACY / HIPAA

HIPAA protections apply; however, maintaining privacy within the home environment is the patient's responsibility.

FINANCIAL TERMS

Travel, mobilization, and appointment fees may still apply if visits are cancelled late or terminated due to unsafe conditions.

CAREGIVER RESPONSIBILITY CLAUSE

For patients requiring assistance due to mobility, cognitive impairment, medical complexity, or fall risk, a responsible caregiver must be present throughout the visit. McDuffie In-Home Dental Care is not responsible for supervision before or after treatment, and caregivers remain responsible for patient safety within the home environment.

PAYMENT AUTHORIZATION & CHARGEBACK PROTECTION

By scheduling services, the patient or responsible party authorizes charges related to scheduled mobile services, including travel and mobilization fees when applicable. Safety-related termination or late cancellations do not void applicable charges. Patients agree to contact the practice directly to resolve billing concerns prior to initiating credit card disputes or chargebacks.

SIGNATURES

Patient Name: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____