General Dentist
Texas Dental Sleep Services, PLLC

Oral Appliance (E0486) Proof of Delivery

CMS Sticker	Laboratory FDA Sticker
Place CMS sticker here	Place Lab sticker here

______________________________ Patient's Name

______________________________ DOB

Oral Appliance Description: The oral appliance fabricated and delivered to the patient is a custom-fit, adjustable oral device designed to reduce the patient's upper airway collapsibility. This oral appliance (OA) meets the following Medicare guidelines of an approved oral appliance: (a) The appliance has a mechanism that is hinged or jointed at the sides, front, or palate, a mechanism that allows the mandible to be advanced, (b) is able to protrude the mandible beyond the front teeth at maximum protrusion, and (c) is adjustable by the beneficiary in increments of one millimeter or less and can retain their adjustment setting when removed.

I ______________________________, have received the following:

- HIPAA Privacy Policy
- Patient's Rights and Responsibilities
- Medicare Supplier Standards
- Informed consent

Quantity: One (1) Oral Appliance - CPT E0486

Items discussed with the patient for using the Oral Appliance:

_____ Insertion and removal of OA: I have been shown how to insert and remove my oral appliance and had all my questions answered to my satisfaction.

_____ Activation of OA**:** I have been shown to my satisfaction how to operate and adjust my OA without causing discomfort.

_____ Possible side effects of my OA: I have had this fully explained to me again, and I am fully aware of the possible side effects of this therapy, as discussed at my consultation.

_____ Pushing my jaw back: I have been shown and understand why I need to use the AM Aligner after wearing the OA and have had my questions answered. I fully understand that this action is only to be done as a comfortable exercise.

_____ Home care: I have been informed of the proper daily care of the appliance and had all my questions answered to my satisfaction.

_____ Received Personalized Instructions: I have received my oral appliance and personalized instruction sheet with my starting position noted. I also understand the information on it and have a good understanding of my responsibilities in my treatment.

_____ Received Appropriate & Fit Oral Appliance: Upon my personal examination, the oral appliance I have just received comfortably fits my mouth and teeth. It does not appear to be substandard, unsuitable, or inappropriate for my treatment needs.

_____ Statement of Satisfaction: I have no concerns or questions that have not been answered satisfactorily. I am aware I can forward my concerns/questions in writing to this office so they can respond in a timely manner.

_____ Damage Disclaimer: I fully understand that if any damages occur, such as pet damage, exposure to excessive heat, loss, etc., I may be charged $1800.00+ replacement fee. This fee is if the damage occurs within the first year after the appliance has been delivered. Beyond this point, a regular fee will be charged for replacement.

______________________________ ______________
Patient Signature Date

____
Patient Name

______________________________ ______________
Witness Date