ELCOME

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on a preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

	Tell Us About Your			General Informa	DIOII
	Today's Date:		Who is accompanying		
nild's Name:	Last First	М	Name:		
			Do you have legal cust		Yes No
	// Child's Age:		Whom may we Thank f		
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I certify that my child is covered by. Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Anything you would like to discuss with the Doctor in private? Yes No					O. IVICCIIC	al History	
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14°, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example

Treatment: We may use or disclose your health information to a dentist or other healthcare provider providing treatment to you

Payment: We may use and disclose your health information to obtain payment for services we provide to you

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include qualify assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: in addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with payment for your healthcare, but only if you agree that we may do so.

Persons involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member your personal representative or another person responsible for your care, of your location, your general location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experiences with common practice to make reasonable inferences of your best interest in allowing a person to pick up arrays or other similar forms of health information.

Making Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT"

1, ha	ave received a copy of this office's	Notice of Privacy Practices
Patient Name:	Da	te:
Parent/Patient/Guardian Signat	ure:	
	FOR OFFICE USE O	NI Y
We attempted to obtain written ack		of Privacy Practices, but acknowledgement was
refused		
Employee Name:	Date	Signature



Office Policies

New Patient Paperwork

Please complete the new patient paperwork prior to arriving to your appointment. When you do not do this, it delays your appointment and other patients after you.

Missed Appointments

Our goal is to provide quality to all of our patients. When an appointment is scheduled, a block of time in the doctors' schedule has been allotted for you and your family.

We reserve the right to charge an initial \$50.00 fee for any missed appointment that has not been canceled 48 hours prior to the scheduled appointment time.

Late Appointments

All patients that arrive more than 15 minutes late for a scheduled appointment may be rescheduled. This does not apply if prior arrangements have been made.

Customary Diagnostic and Preventative Services

All patients are recommended to have an exam, a dental cleaning and a professional fluoride application minimally on a biannual basis. Dental check-ups periodically will involve radiographic films when age appropriate and will be taken with a frequency supported by the guidelines of the American Academy of Pediatric Dentistry.

Unable to COMPLETE Treatment

If we are unable to complete treatment due to behavior; there is a \$50 Behavior Management Fee AND if Nitrous Oxide (N2O) is also being utilized, an additional \$75 will be applied.

Financial Responsibility

Your signature on this form acknowledges that you, the patient, parent, or legal guardian, agree to bear full financial responsibility for all services provided if:

- You are determined not to be eligible for insurance coverage.
- 2. The services are not a covered benefit under your plan.
- 3. There is a patient portion determined by your insurance plan.

Please keep in mind that any estimates presented to you for dental treatment is only an ESTIMATE of what your insurance company will pay. Financing options are available.

Returned checks

A fee of \$35.00 for returned checks returned to us for any reason. Future services will require payment by cash or credit card.

Signature	Date
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