Sunny Smiles Dentistry for Children and Young Adults

Welcome to our "specialty" pediatric dental practice. You have chosen to bring your child to us so that we may monitor his/her oral health and provide preventive, as well as restorative care if needed, throughout their life. We will conduct a complete oral diagnostic evaluation consisting of an exam, as well as a cleaning and fluoride treatment. Possible radiographs may be taken depending on the stage of your child's growth and development (radiographs are an integral part of complete diagnosis).

Being a "specialty" pediatric dental practice, our physical environment is designed to enhance and promote a positive experience of "going to the dentist". Our expert staff is focused and dedicated on caring for the special needs of your child. Please do not hesitate to communicate any and all concerns that you, as the parent/guardian, might have regarding your child's visit to the dentist.

The following are several office policies that relate to the business/billing part of our practice.

(1) We will bill all PPO insurance plans as a courtesy. Dental claim submission is done as a courtesy the day of the appointment. Proof of Dental Insurance is required. Ultimately, payment is your responsibility if insurance is slow to pay, denies payment, or if you give us incorrect information. We must ask that the balance be cleared within 60 days. Professional Dental Services rendered are the SOLE LIABILITY of the child's parent/guardian whose signature appears on this form.

(2) Every appointment represents a specific amount of time reserved for your child. Should you fail to keep your child's appointment without properly notifying our office 24 business hours prior to that appointment, a minimum fee of $50.00 will be posted to your account.

(3) To ensure the privacy and protection of everyone in our office, recording of any kind within the practice is strictly prohibited.

Thank you for signing and dating this form. It will be placed in your child's dental chart.

_____

Signature: Parent/Guardian **Date**

_____

Please print name

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION B: TO THE PARENT/GUARDIAN---PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke the Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I consent to the dental practice using my cell phone number to (choose one or both) Call or text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.
My cell number is (including area code) _____
_____(initial)

Signature: _____ ***Date:*** _____

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I have received a copy of the Dental Materials Fact Sheet.

_____

Patient/Parent Signature ***Date***

Print