SUNNY SMILES DENTISTRY FOR CHILDREN AND YOUNG ADULTS - PRACTICE POLICIES

Welcome to our "specialty" pediatric dental practice. You have chosen to bring your child to us so that we may monitor their 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 team 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/legal guardian, might have regarding your child's visit to the dentist.

You understand and acknowledge that you are fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. You acknowledge that any insurance coverage or managed care benefit that the patient may have is based on a contract between the insurance company or managed care company and yourself, spouse, and/or employer. The dentist is not a party to this contract and the services, treatments, procedures, and/or diagnostic methods are provided to the patient; therefore, you acknowledge that you are fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures, and/or diagnostic methods provided to the patient. As a courtesy to you, the dental office will bill the insurance company or managed care company and you acknowledge that you will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. You acknowledge that it is your responsibility to provide the dentist with the current insurance or managed care information and any changes thereto.

You consent to the dentist's use and disclosure of your or your child's health information to your insurance company or managed care company and any agent thereof. You hereby assign to the dentist all of the insurance and managed care benefits due to you for the services, treatments, procedures, and/or diagnostic methods provided to you or your child, and you authorize your insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

You further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred (a) by mail at any address that you provide to the dental office and/or (b) at any facsimile number, email address, or phone number (whether a cell phone or landline) that you provide to the dental office or any agent of the dental office.

All returned checks will be subject to a $35.00 returned check fee. For any payment that you make by credit card or by debit card to the dentist or any collection agency to which your account has been assigned, you authorize the dentist or collection agency to add to each such payment the fee or charge actually incurred by the dentist or collection agency for processing the credit card or debit card payment not to exceed $10.00 per payment. Any account balances that remain unpaid for over 90 days from the date of service may be referred to a collection agency. In the event this occurs, you understand that you will be liable for collection costs.

Patient Name: _____ Patient D.O.B.: _____

Continued on reverse…

Parent/Legal Guardian Name: _____ Mobile Number: (_____)_____

Parent/Legal Guardian Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PARENT / LEGAL GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form you will consent to our use and disclosure of your or your child's 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, healthcare operations, the uses and disclosures we may make of your or your child's protected health information, and of other important matters about your or your child's 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 our office. 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 your child or to continue treating your child if you revoke this Consent.

I have had the full opportunity to read, understand, and agree to the contents of this Consent form, Practice Policies, Notice of Privacy Practices, and the Dental Materials Fact Sheet. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my and/or my child's protected health information to carry out treatment, health care operations, and any accounting, billing, or collection activities. I consent to the dental practice using my mobile phone number to 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.

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