A Tooth Doctor for Kids
Pediatric Dentistry

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Consent for Pediatric Dental Procedures

Please read this information carefully and ask about anything that you do not understand.

- ☐ Routine check up visits, done very 6 months, always include an oral exam, a cleaning, fluoride treatment, and any necessary X-Rays. If you have any questions, please let us know ahead of time at each visit.
- ☐ I hereby authorize the dentist, staff under her employ, and other dental/medical auxiliaries, to perform procedures for my child, including the use of any necessary or advisable advanced pediatric behavior guidance techniques, fluoride preparations, radiographs (x-rays), or diagnostic aids, which may be necessary for treatment.
- ☐ Although the occurrence is extremely remote, some risk is known to be associated with dental treatment. This could include numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, and allergic reactions.
- ☐ I acknowledge that all financial responsibility for all dental treatment is due at the time services are rendered. For those with insurance coverage, an estimated share of cost is due on the appointment day.
- ☐ The undersigned hereby read and understand the financial responsibility indicated on the Patient Information Sheet and the Office Welcome Letter. Should the account be referred to an attorney or third party, the undersigned shall pay actual attorney's fees and other collection expenses. All delinquent accounts shall bear interest at the legal rate.
- ☐ I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
    - Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
    - Obtain payment from third-party payers.
    - Conduct normal healthcare operations such as quality assessments and physicians certifications.
- ☐ I have been informed and have read the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I also understand that Suelene Y. Chen, DDS, Inc. has the right to change the *Notice of Privacy Practices* from time to time and that I may contact the office at any time to obtain a current copy of the *Notice of Privacy Practices.*
- ☐ I understand that I may request in writing restrictions of how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Suelene Y. Chen, DDS, Inc. is not required to agree to my requested restrictions.
- ☐ I understand that I may revoke this consent in writing at any time, except to the extent that the dental office has taken action relying on this consent.
- ☐ I understand that successful completion of treatment depends on keeping appointments as scheduled. A charge may be applied for broken appointments or appointments cancelled with less than 48 hours notice.
- ☐ The treatment plan has been explained to me. Alternate methods of treatment, if any, have also been explained as have the advantages and disadvantages of each procedure.

I have read and understand this consent form and all questions about the procedure(s) have been answered in a satisfactory manner.

PATIENT NAME: ____

PARENT/GUARDIAN SIGNATURE ______________________________ DATE: __________

RELATIONSHIP TO PATIENT: ____________________________________