PEDIATRIC DENTISTRY of
MIDDLE TENNESSEE, PLLC

STEPHEN SIMPSON,DDS,MS
CREATING HAPPY SMILES

Pediatric Dentistry of Middle Tennessee, PLLC

Privacy is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

The parent or legal guardian must complete this form for a minor, provide consent for dental treatment, and accompany the child during the initial dental visit.

Your Child(ren)'s Names:

Patient's Name_____DOB: ___ /___/___

Patient's Name_____DOB: ___ /___/___

Patient's Name_____DOB: ___ /___/___

Patient's Name_____DOB: ___ /___/___

Patient's Name_____DOB: ___ /___/___

Patient's Name_____DOB: ___ /___/___

Clinical

1. As the parent/legal guardian of the child(ren) listed above, I authorize Pediatric Dentistry of Middle Tennessee to perform all recommended treatment on the patient, including but not limited to:
    a. All recommended treatment;
    b. Radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis;
    c. The use of anesthetics, nitrous oxide, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Maintaining Appointments

2. I am aware that when appointments are broken or cancelled at the last minute, valuable clinical time is voided, time that could have been spent serving another patient, especially a patient in pain. I am aware that a failed appointment is an appointment that is cancelled/ rescheduled without 24 hours' notice or an appointment where a patient does not show up. After two (2) failed appointments, I understand a $75 deposit to hold the appointment time may be required in order for me to reserve any further appointments. After three(3) failed appointments, I risk being dismissed from the practice

Financial

3. I am responsible for payment for all services rendered for my child. I understand that payment is due when services are rendered.

Insurance

4. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I understand that my dental benefits through my insurance company are not intended to dictate my child's treatment, only to help offset the cost of dental expenses. I am responsible for payment regardless of coverage provided.

HIPAA Acknowledgment

5. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, specialty dentists involved in my child's care, any and all information, records, and other diagnostic material about my child's medical history, services rendered, or recommended treatment.
6. I acknowledge receipt of the Notice of Privacy Practices.

7. I authorize sharing my child's protected health information with the following individuals who may be involved in my child's care and I understand I am responsible to notify the Practice of any changes. The name(s) listed below are family members or friends to whom I grant permission for Dr. Stephen E. Simpson and representatives at his practice to verbally discuss my child'(s) care using their best judgement and grant them permission to disclose dental information that is relevant to my care such as: appointment changes, cost estimates, account payments/balances, needed treatment/completed treatment.

   a. Name: _____ Relationship: _____Phone:_____

   b. Name: _____ Relationship: _____Phone:_____

   c. Name: _____ Relationship: _____Phone:_____

Electronic Communication Consent

8. I agree that Pediatric Dentistry of Middle Tennessee may communicate with me electronically at the email address/mobile number below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am aware that standard text message charges from my cell phone provider may apply. I authorize the following means of communication:
   Home Number: _____ to include a message

   Mobile Number: _____ to include a text message and voice message

   Email: _____Other: _____

   I can withdraw my consent to email/text communications anytime by calling 615-890-0454.

I have read this Patient Consent and agree to all terms and conditions herein.

Parent/Legal Guardian's Signature: _____***Date:***_____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining the acknowledgement
- □ Other (Please Specify) _____

Staff Person Initials_____