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 each dental visit. Treatment will not be provided for unattended minors unless it is an emergency. If you wish to designate another adult to be a decision-maker in your child's dental care, please complete the Limited Power of Attorney. If you authorize sharing protected health information, complete the HIPAA Acknowledgment section below.

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.

Financial

2. I am responsible for payment for all services rendered for my child. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

Maintaining Appointments

3. 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. A $50 missed appointment fee may be charged to my account for all missed appointments or last-minute cancellations by me.

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 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:
    a. Name: _____ Relationship: _____
    b. Name: _____ Relationship: _____
    c. Name: _____ _____ Relationship: _____
8. 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 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_____