Pediatric Dental Care of Wilmington

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices for Pediatric Dental Care of Wilmington, I hereby authorize, as indicated by my signature below, for Dr. Gabrilowitz to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____	_____	
Print Name of Patient	Address	
_____	_____	_____
Print Name of Parent or Legal Guardian	Signature (Parent or Legal Guardian)	Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added / Removed:_____

2. _____Date Added / Removed: _____

3. _____Date Added / Removed: _____

4._____Date Added / Removed: _____

5._____Date Added / Removed: _____

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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 _____

PATIENT CONSENT (MINOR)

Clinical

1. As the parent/legal guardian of _____ ("Patient"), I authorize Pediatric Dental Care of Wilmington to perform all recommended treatment on the Patient.

2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payers and/or other health professionals.

3. I authorize the use of anesthetics, 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

4. I am responsible for payment for all services rendered on behalf of the Patient. I understand that payment is due when services are rendered. I am aware that a billing fee will be automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs including reasonable attorney fees.

5. A $75 Missed Appointment Fee will be charged to my account for all missed or last minute cancellations by Patient. I am aware that to hold down operating costs, a notice of at least 2 working days is required for any cancellation or change of appointment

Insurance

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and radiographs about the Patient's medical history, services rendered, or recommended treatment.

7. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf or on Patient's 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 the coverage provided.

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

Patient's Name: _____ DOB: _____

Signature of Parent/Guardian: _____ Date: _____

Relationship to Patient: _____ Address: _____