OFFICE POLICIES

We appreciate you for allowing us to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding we offer these explanations of our office policies.

PATIENT INFORMATION

Patient Name_____ DOB_____/_____/_____ M F

Address _____

Email _____ Contact Phone #_____

With whom does the child live with? Mother Father Other _____

Who has legal custody of the child? Mother Father Other _____

How did you hear about our office? _____

PARENT/GUARDIAN INFORMATION

Mother Step Mother Guardian

Name_____ DOB_____/_____/_____ SSN_____

Father Step Father Guardian

Name_____ DOB_____/_____/_____ SSN_____

Parent's marital status**:** Single Married Partnered Divorced Separated Widowed

Person responsible for payment on this account

Name_____Relation_____

Billing Address _____

Email _____

Home phone _____Cell phone _____

DENTAL INSURANCE

Primary Insurance _____

Employer/Group Plan_____

Policy holder's name _____DOB_____/_____/_____ SSN _____

Insurance Address _____

Group #_____Subscriber/Member ID_____

Secondary Insurance_____

Employer/Group Plan_____

Policy holder's name _____DOB_____/_____/_____ SSN _____

Insurance Address _____

Group #_____Subscriber/Member ID_____

MEDICAL HISTORY

Pediatrician _____Previous Dentist _____

Are your child's immunizations up to date? YES NO

Medications? (If yes, please list) YES NO _____

Allergies? (If yes, please list) YES NO _____

Please circle ALL that apply:

AIDS/HIV	Birth Defects	Down Syndrome	Headaches	Liver Disease	Social Delays
Anemia	Cancer/Tumors	Endocrine Issues	Heart Condition	Mental Delays	Speech
Asthma	Cerebral Palsy	Epilepsy/Seizures	Hepatitis	Physical Delays	Stomach/GI
Autism	Cleft lip/Palate	Excessive Bleeding	Immune Deficiency	Psychological Issues	Tuberculosis
Blood Disorder	Diabetes	Frequent Infections	Kidney Disease	Rheumatic Fever	Other

Please elaborate on all items circled _____

◯ **Patient has never been diagnosed with any of the above conditions**

I agree that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform Charlottesville Pediatric Dentistry of any changes to my information and my child's medical status.

_____

Parent Signature Date

CONSENT FOR DENTAL TREATMENT:

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Aaron J. Stump, Dr. Jennifer M. Dixon and their staff to perform any necessary dental services including, but not limited to: examinations, cleanings, fluoride treatments, X-rays as necessary to diagnose and/or treat my child's dental problem, any necessary dental treatments as discussed, and administration of anesthetics. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Dixon, Dr. Stump, and staff will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones.

FINANCIAL POLICY:

I authorize Charlottesville Pediatric Dentistry, to provide insurance carriers with any medical information necessary to process insurance claims. I hereby assign all payments from my insurance company for all services rendered to my child, to Charlottesville Pediatric Dentistry.

Payment for services is due in full by cash, check, or charge card at each appointment at the time services are rendered. All services not covered by your insurance are your responsibility and will be billed to you. We accept Visa, MasterCard, American Express and Discover. A charge of $35.00 will be assessed on checks returned for any reason.

All accounts **60** days past due will be turned over to a Collection Agency.

I understand that I am responsible for payment of any amount not paid by my insurance company. As a courtesy, not an obligation, Charlottesville Pediatric Dentistry will file dental insurance for you.

I agree to pay all cost of collections including but not limited to 35% collection fees and attorney fees of 35% but not less than $200.00, regardless whether or not suit is filed.

All emergency treatment must be paid in full at the time services are rendered. If an emergency occurs after normal business hours, an "After Hours Office Visit Fee" of $250.00 is due at the time of service.

I have read and understand my financial obligation to Charlottesville Pediatric Dentistry.

APPOINTMENT REMINDERS AND CANCELATION POLICY:

I permit, as a courtesy, Charlottesville Pediatric Dentistry to give me appointment reminders via text message, email, and/or phone calls. I understand there is a 24 hour cancellation policy. Although unforeseeable circumstances arise, I understand I am required to give a 24 hour cancellation notice from time of my child's appointment. I understand there is a **$40.00** fee for all missed Recall Appointments and a **$75.00** fee for missed Restorative Appointments. If more than 2 scheduled appointments are missed we will no longer be able to provide dental services to your child. This policy is to protect dental appointment times for your child and other children that need care.

I have read and understand Charlottesville Pediatric Dentistry's Appointment Reminder, Cancellation Policy and Financial Policy.

X_____Date_____

We appreciate you for choosing Charlottesville Pediatric Dentistry for your child's dental care. We look forward to years of close association with you as we work together to maintain your child's oral health.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health Information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your-health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services; etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost- management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (Phone, email or mail) or provide you with information about treatment options or other health-related services including release of Information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are Involved In a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release Information 10 order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations ·that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another Individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction. We must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices,
Privacy Office
Charlottesville Pediatric Dentistry
1620 Timberwood Blvs. Suite 201
Charlottesville VA, 22911
434-975-7336

For more Information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

X_____ Parent/Guardian Signature