

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

*Purpose of Consent:* By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

*Notice of Privacy Practices:* You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting it from us or print the online version.

*Right to Revoke:* You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we will decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described in the "Notice of Privacy Practices."

Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_



## ASHEVILLE PEDIATRIC DENTISTRY FINANCIAL POLICY

Thank you for choosing our office 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 payment for services:

### 1. Payment:

- a. Payment is due in full by cash, personal check, or charge card at each appointment as services are rendered.
- b. We accept Master Card, Visa, and Discover.
- c. A charge of \$30.00 will be assessed on checks returned for any reason. After two incidents of returned checks, we will no longer accept checks.

### 2. Dental Insurance:

- a. Dental insurance is a contract between your employer and the insurance company. We cannot influence how much of our fees your insurance will cover. Your benefits are determined by the policy your employer purchased.
- b. As a courtesy to you, we would be happy file your claim. Your insurance will reimburse you directly for what they cover.
- c. Please be aware that the person bringing the child for dental care is legally responsible for payment of all charges.

### 3. Pretreatment Authorization:

- a. Some insurance companies request an estimate of the work to be done and the fees to be charged before determining their benefits to you (i.e., Impacted Canine Exposure).
- b. We will give you an estimate of necessary treatment and our fees which you may convey to your insurance company.
- c. It will be up to you to determine if you wish to proceed with treatment before the insurance benefit is determined.

### 4. Fillings:

- a. We offer white fillings (composite resins) and silver fillings (amalgams).
- b. Please understand that some insurance companies do not pay for a white filling (composite resin) at the same level as a silver filling (amalgam).
- c. In some cases, when the cavity is too large to be restored with a composite resin, the tooth will need to be crowned
  - i. We use silver stainless steel crowns.
  - ii. If the tooth requires nerve treatment (pulpotomy or pulpectomy), the tooth will need to be crowned with a silver stainless steel crown.

### 5. Nitrous Oxide:

- a. Nitrous oxide is an inhalational sedation technique often used by pediatric dentists.
  - i. Nitrous oxide is a slightly sweet smelling inert gas that induces a sense of well-being and relaxation.
  - ii. It is very safe, perhaps the safest sedative agent in dentistry.
  - iii. It is non-addictive. It is mild, easily taken, and then quickly eliminated by the body.
  - iv. Your child remains fully conscious, keeps all natural reflexes, when breathing nitrous oxide/oxygen.
  - v. Nitrous oxide is not always covered by dental insurance.

### 6. Oral Sedation:

- a. Conscious sedation is a management technique that uses medications to assist the child to cope with fear and anxiety and cooperate with dental treatment
- b. Who should be sedated?



- i. Children who have a level of anxiety that prevents good coping skills or are very young and do not understand how to cope in a cooperative fashion for the delivery of dental care should be sedated.
- ii. Conscious sedation is often helpful for some children who have special needs.
- c. Oral sedation is not always covered by dental insurance. We thank you for the payment the day you schedule your child's oral sedation appointment.

**7. Appliances:**

- a. The cost of the appliance (space maintainer) is due the day the impression is taken. This is necessary because our office must pay for the lab fees when appliances are ordered, not when they are completed.
- b. Space maintainers are not always covered by dental insurance.

**8. Emergency Treatment:**

- a. All emergency treatment must be paid in full at the time the service is rendered.
- b. If an emergency occurs after normal business hours, an "After Hours Office Visit Fee" will be assessed and you will be billed the next business day.

Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation is greatly appreciated!

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

Legal Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_



## ASHEVILLE PEDIATRIC DENTISTRY APPOINTMENT INFORMATION

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. If a cancellation is unavoidable, please call our office **at least 24 hours** in advance so that we may give that time to another patient.

- One parent is welcome back for their child's dental visit. The exception is during conscious sedation appointments, where we ask that the parent waits in the reception area.
- *All restorative (fillings, extractions, etc.) procedures for young children are scheduled in the morning.* Children, as well as adults, are more prepared and do better in the morning for these types of procedures.
- We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.
- *If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.*
- Broken or missed appointments affect many people. If a broken/missed appointment occurs or a cancellation without 24-hours notice, our office reserves the right to NOT schedule any subsequent appointments and/or charge a broken appointment fee.
- *A parent or legal guardian (with official documentation) must be present during all appointments that the child patient is in the office.*

I have read and understand the appointment information.

Legal Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release healthcare information of the patient named above to:

Name: Asheville Pediatric Dentistry

Address: 76 Peachtree Rd, Suite 100

City: Asheville State: NC Zip Code: 28803

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Legal Guardian's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

