Safari of Smiles

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Patient Name: _____ * _____ * ____ _____

Last First MI Preferred Name

Consent for Office Policies and Services

Punctuality and Patience:

Dr. Alvarez strives to serve you efficiently and effectively in a child friendly environment. Appointment times and lengths are service driven. We appreciate your punctuality and patience. Our teams focus is on your child's well being during all appointments, giving the children and parents individual attention that they need from Dr. Alvarez is our priority. If you would like to speak with Dr. Alvarez at anytime feel free to ask and she will make herself available to answer all of your questions.

Legal Guardian Required:

A parent or legal guardian must be present during all treatment planning sessions. If this is not possible, the parent must obtain a notarized letter granting a second party permission to make all dental treatment planning decisions, including behavior management and sedation when necessary.

Confirmation Consent:

I request and authorize Dr. Alvarez and/or her staff to confirm appointments. I understand that a message may be left with a second party or on a message machine. Pre and post operation information will be provided

I request and authorize Dr. Alvarez and/or her staff to mail me a reminder for periodic evaluations.

Parents in Clinic Area:

A one-on-one relationship is developed with every child and an efficient environment is maintained during every procedure. For this reason, only the doctor and assistant are permitted in the clinic area. An iPad is provided upon request allowing the legal guardian to observe their child's appointment during their visit.

I have been made aware of the diagnostic treatment prescribed for my son/daughter and am fully aware of the side effects and risk factors involving such diagnostic treatment. I hereby authorize and consent to Dr. Alvarez's recommended diagnostic procedures, advisable in the diagnosis of my child who is a minor. By signing this medical authorization and consent, I understand that as matter of law it shall be conclusively presumed, that the action of Dr. Alvarez in obtaining this consent from me was in accordance with an accepted standard of medical-dental practice among members of the medical-dental profession with similar training and experience in this or similar medical communities; and from information provided me by Dr. Alvarez, I, understand these circumstances, have at least a general understanding of the procedures, the medically accepted alternate procedures or treatments and the substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this or a similar community who perform similar treatments or procedures.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Consent for Office Policies and Services Form.**

Consent for Behavior Management

As pediatric dentists, we enjoy treating children, but there are a variety of concerns when dealing with their behavior. Some children may need assistance to cooperate. They may cry because they are nervous and not due to discomfort. That is why we have received special training to help guide children through the dental experience and make it a pleasurable one. Parents will not be requested to assist office staff in the behavior management of their children. The purpose of this form is to explain the various methods we may use to manage young children, to get your consent for use of these methods with your child, and to familiarize you with some of our office policies. Please note: During all dental procedures, the child's cheeks and lips will be retracted. It is common for instruments to leave imprints, and/or cause redness of the skin.

Tell-show-do is a method used with children in which we explain what is to be expected at each visit. First, we tell them what is to be done. Then we show them how it is done, and finally we do the procedure. Voice control is a method that we use with a child who is capable of understanding, but is not listening to what we are saying. After several unsuccessful attempts of trying to communicate with the child, we change the tone or volume of our voice to convey a firm attitude, but we do not get angry with the child. Once we have their cooperation and attention, we praise the child for helping.

☐ * **I authorize Dr. Alvarez and her assistants as selected by her, to utilize the aforementioned behavior management techniques, as they deem necessary to treat my child who is a minor. I understand the office policies as written and explained to me and agree to adhere to these policies while my child is undergoing dental treatment.**

Financial Policy

This financial policy is to help you understand the financial aspects of your visit to our office. Dentistry is no different than any other service oriented business. Payment is due when services are rendered. We do not participate with ANY insurance companies. Insurance estimates are presented as "estimates only". Fees are valid for 180 days, and are subject to change thereafter. If you provide us with your current insurance information, as a courtest we will file claims to your primary insurance carrier for you. You are ultimately responsible for

100% of the entire amount of treatment completed if your insurance company fails to pay their portion.

Unlike medical insurance, most dental insurance companies have annual maximum benefits that significantly limit the amount of dental coverage especially if your dental needs are extensive. We have excellent relationships with many insurance companies, but we have no way of knowing any limits you may have reached or any remaining balances that will be applied towards your deductible. Some insurance companies may deny benefits for routine dental procedures. If after 60 days, your insurance company has not paid your claim, we will forward the unpaid balance directly to you for payment. Upon receipt of insurance payment, any unpaid balance over 90 days will be sent to a collection agency. You will be responsible for any delinquent fee added to your account. Additional surcharges of up to 35% may apply. A $35 finance charge will be applied to any balance over 30 days. A $25 charge will be applied for checks with non-sufficient funds from pre-approved check payors. Cancellations without 24hrs notice will be subject to a $75 cancellation fee and a $150 cancellation fee during school holidays and breaks.

☐ * **I understand that my insurance plan may not cover any part of the charges, costs, or expenses related to the dental treatment rendered and I will be responsible for all charges incurred. I have read the above conditions of treatment and payment, agree to their content and this will serve as my electronic signature for the Financial Policy form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians: (example: John Doe (212-555-1212)

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Name of the person completing this form: * _____

Relationship to the patient: * _____

Response Date: _____