Hamilton
Pediatric Dentistry P.C.

Consent for treatment Form

Child's Full Name_____ DOB _____

I am the parent or legal guardian of the patient and there are no court orders now in effect that prevent me from signing this consent. I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. I authorize Dr. Hamilton and her staff to perform any necessary dental treatment for my child including but not limited to comprehensive exam, cleaning, x-rays, fluoride treatment, administration of local anesthetic, use of nitrous oxide, fillings, crowns, nerve treatment, and extractions whether or not I am present at the time treatment is rendered.

For the purposes of advancing medical-dental education, I give permission for the use of clinical photographs and patient information.

I understand that it is my responsibility to inform Hamilton Pediatric Dentistry of any changes in my child's medical status.

_____ _____

Signature of Parent/Guardian Date

Authorization for Non Parent to Bring Child to Appointment

I authorize _____ (Name & relationship of person accompanying child) to accompany my child, _____ to his/her dental appointment. I agree to the following treatment to be performed in my absence:

Any necessary dental treatment for my child including but not limited to comprehensive exam, cleaning, x-rays, fluoride treatment, administration of local anesthetic, use of nitrous oxide, fillings, crowns, nerve treatment, and extractions.

I request that I be contacted at the phone number below if treatment needs or recommendations change during treatment. Phone Number: _____

If treatment recommendations change during treatment and I am not able to be reached, I authorize the person accompanying my child to make an informed decision and authorize Dr. Hamilton to perform the treatment.

Parent/Legal Guardian Name: _____

Signature: _____

Date: _____ ***This authorization is good for one year from date.***

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Patient HIPPA Acknowledgement and Consent Form

Child's Full Name: _____ DOB: _____

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information accept for our disclosures in connection with; a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation: an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patients Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.
I acknowledge that I have today received a copy of the Notice Privacy Practices.

X_____ X_____

Signature of Patient or Legal Guardian Print Patient or Legal Guardian Name

Date:_____ X_____

Witness

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

X_____ X_____

Signature of Patient or Legal Guardian Print Patient or Legal Guardian Name
Date:_____

For Office Use Only:
_____Patient refused to sign

_____The following circumstances prohibited the patient from signing the acknowledgement: _____

_____An emergency situation prevented the patient from signing the Acknowledgement: _____

X_____ X_____

Office personnel (signature) Office personnel (print name) Date: _____

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Office Financial Policy

Child's Full Name_____

We appreciate you allowing us to provide dental care for your child. Because we value our relationship with you and we believe that the best relationships are based on understanding, we offer clarifications of methods of payment for services.

- We will be happy to file your insurance claim on the first visit if we have received all of your insurance information. You will need to be prepared to pay any amount that is determined not payable by your insurance plan, such as deductibles and percentages.
- We request that estimated co-pays are collected in full by cash, check, or charge/credit card at each appointment as service is rendered. Estimated co pays are collected in full by cash, check or credit/charge cards at each appointment as service is rendered is requested. For your convenience, Visa, MasterCard and Discover are accepted.
- The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.
- To ensure prompt and efficient patient care, we require 24 hour notice to reschedule or cancel appointments. A $50.00 reactivation fee may be assessed in order to reschedule if 24 hour notice is not given.
- We are dedicated to providing the best treatment for our patients and our fees are based on the most appropriate treatment for your child. Please note the following:
    1. We must emphasize that as health care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer, and the insurance company. We are not a part to that contract.
    2. The amount not covered by your insurance is payable at the time of service, such as deductibles and co-payments. However, if we do not receive payment from the company within 45 days after the submission of a claim, you will be expected to pay for all dental services in full within 10 days of notification. In the event of duplicate payment, you will be reimbursed.
    3. You are responsible for payment regardless of any insurance company's arbitrary determination of fees. Please be aware that some services provide may be a non-covered service by your dental insurance carrier.
    4. All charges for services rendered that remain unpaid 30 or more days will be subject to a 1.5% monthly finance charge/late fee (18% annually) or a minimum monthly finance charge/late fee of $25.00, whichever is greatest.
    5. A charge of $25.00 will be assessed on any returned check.
    6. Should your account be turned over for collection, you will be responsible for all cost of collection, without limitation, attorney's fees, and court costs.

We will do our best to maximize the insurance benefits that you are eligible to receive and we do appreciate your prompt settlement of any charges that may be incurred during treatment. We look forward to years of close association with you as we work together to maintain your child's oral health.

I have read and understand the Office Financial Policy and agree to abide by its contents.

Parent/Guardian: _____Date: _____