Dentistry for Children

PRIVACY ACT

1116 South Stapley Drive
Building B, Suite 102
Mesa, Arizona 85204
480-610-6544 • 480-633-0670 Fax

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such a **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Parent Signature: _____

Relationship to Patient: _____

Date: _____

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Thank you for choosing Dentistry for Children to serve you in your dental care. We look forward to providing you with dental service and treatment.

In order to provide you with the outmost in dental care, we would like to establish some guidelines.

Courtesy Reminders: The day before your appointment we will call you to remind you of your appointment. Please keep in mind that this is provided as a **courtesy only** and that you (patient/parent/guardian) are **ultimately responsible** for keeping your appointment.

Cancellation Policy: We require a 24-hour advance of cancellation. If you are unable to make your appointment, please call us to let us know so that other patients who are in need of treatment can be scheduled accordingly.

Failed Appointments: Patients who do not show up to their scheduled appointments without 24 hour notification will be considered missed/failed appointments. After 3 missed appointments, patients will need to seek dental treatment through another dental provider.

Tardiness: Patients who are more that 15 minutes for their appointment will not be seen and will need to be re-scheduled. Treatment will be rendered at the discretion of the dental provider.

Financial Policy: Our office will be happy to submit any insurance claims for your child. Any co pays, deductibles, or known percentages need to be paid the day of service. However, please remember that in most cases these figures are only estimates. We will also be happy to pre-authorize any treatment through your insurance company. We cannot guarantee what your insurance will pay. You will be responsible for any services not covered by your insurance carrier. Due to the large volume of patients that we care for, we will be unable to make any calls to your insurance company on your behalf.

I agree to pay all finances charges, collection costs of 33% , attorney fees and all other costs that may incur to enforce collection of any amounts outstanding.

I acknowledge that I have read, understand, and am willing to comply with the above financial responsibility.

Thank you for your time and cooperation in this manner. We look forward to serving you in your dental care.

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Signature: _____ **Date:** _____