Child's Full Name:_____

Name child prefers to be called:_____

Please tell us if there have been changes in the following information

To assist us in keeping your child's medical history current, please answer the following questions:

1. Have there been any changes in your child's general health since your last visit to our office? If yes, please explain: YES NO
   _____
   _____
   _____

2. Has your child been in the hospital within the last year? If so, for what reason? YES NO
   _____
   _____
   _____

3. Is your child currently under the care of a physician? If so, what is the condition being treated? YES NO
   _____
   _____
   _____

4. Is your child taking any drugs or medications at the present time? If so, please list them below: YES NO
   _____
   _____
   _____

5. Is there any additional information that you think we should know about your child's physical or emotional health state? YES NO
   _____
   _____
   _____

<OVER>

My Kids' Dentists requires two direct contact numbers and one email address to ensure that our office staff is able to reach you to confirm your child's appointment.

Please note that is your responsibility to provide our office with working contact information and to alert our office of any changes immediately.

If My Kids' Dentists is unable to reach you to confirm or give notice of expected out of pocket expenses, we reserve the right refuse treatment on the scheduled day. As seen in our financial policy, broken and or missed appointments without 48 business hours notice a $50, per child, fee may be assessed.

Preferred phone_____ Secondary phone_____

Email_____

Signature of Parent or Guardian_____ Date_____

My Kids' Dentists Policies

Thank you for choosing our practice for your child's dental care. We are committed to their successful treatment. Please understand that payment of your bill is considered a part of your child's treatment. We ask that you review and understand the following details of My Kids' Dentists financial policy and patient responsibilities.

- Please be aware that the parent/legal guardian accompanying the child to My Kids' Dentists as the responsible party is legally responsible for payment of charges. Statements cannot be sent to other persons.
- Payment is expected in full on the day of your child's appointment, as services are rendered. For your convenience we accept cash, VISA, MasterCard, American Express, and Discover. We also offer patient financing through Care Credit.

My Kids' Dentists is in network with Cigna PPO, Humana PPO, and United Concordia. My Kids' Dentists accepts most other insurance plans and will file claims on your behalf. *Please be aware there is no direct relationship between our practice and your insurance company. The plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in selection of your insurance company, no control over the terms of your contract, the methods of reimbursement, or the determination of your insurance benefits. We will accept assignment of benefits from your insurance company; however, you are responsible for the entire balance including any amount that is not paid by your insurance company.*

- We will file your claim electronically as a courtesy, but if your insurance company does not pay us directly, you are responsible for the entire balance and the insurance company will send payments directly to you.
- Please note, that any out of pocket expenses paid at time of service are just an estimate. Our practice works diligently prior to your visit to create the best estimate based on the history of past insurance payments. However, there may be an account balance or credit due to you following your appointment. Refund checks are issued on a monthly basis.
- Our office will happily share any estimated out of pocket expenses with you when confirming your appointment. However, note that this information cannot be left on a voicemail due to privacy policies. It is your responsibility to contact our office to confirm your appointment if you wish to receive any financial information.
- My Kids' Dentists requires that all outstanding balances be paid in full within thirty (30) days unless other arrangements have been made. If we have not received payment or you have not contacted us within that time, further action may be taken with a collection agency or small claims court.
- In the event that your account becomes more than thirty (30) days past due a monthly fee of $5.00 will be assessed to your account, as well as a $30.00 fee if a collection agency is necessary.

***Broken and Missed Appointments**

- **We kindly request that when our staff reaches out to remind you of your child's appointment, if you are unable to be reached, that you contact our office immediately to confirm. Our office reserves the right to remove your child from the schedule should we not be able to confirm your reserved appointment time.**
- **If your appointment is broken or missed without a forty-eight (48) business hour notice, My Kids' Dentists will assess a $50.00 broken appointment fee.**
- **Our office offers a fifteen (15) minute grace period for all appointments. If you arrive after that grace period our office is happy to make every attempt to accommodate your child's appointment. Please note this is NOT a guarantee that your child will be seen. In the event we are unable to work your child back into our busy schedule, we reserve the right to assess a $50.00 broken appointment fee.**
- **All broken appointment fees must be paid prior to scheduling a new appointment.**

A Courtesy for You

Although some offices refuse to file insurance claims for their patients, it is our pleasure to extend this courtesy to our patients. When we file insurance claims, please be aware that this courtesy requires significant amount of time and expense on the part of our staff. Be aware that it takes, on average, thirty (30) minutes to one full business day to verify benefits. Additionally, it is imperative that we are informed of any insurance policy changes at a minimum of forty-eight (48) business hours prior to appointment. Our office reserves the right to remove your child from our schedule should we be unable to verify your benefits prior to your child's visit.
Note, that should this occur, a $50.00 broken appointment fee may be assessed.

Acknowledgement

I acknowledge that I have read and understand the above information. I acknowledge that I am financially responsible for all costs of treatment, including any balance unpaid by insurance. I acknowledge that I have read and understand all policies relating to broken appointments as well as unpaid balances.

Signature_____Date_____

Witness_____Date_____

HIPAA – Acknowledgment of Receipt of Notice of Privacy Practices

As of April 2003, the Health Information Portability and Accountability Act (HIPPA) took effect and we want you to know that we take this seriously. Our office is HIPAA compliant when handling your private health information. We may at times be required to electronically submit your information related to insurance claims or in association with treatment in conjunction with another healthcare provider or interested party. Our record systems are secure and we make every effort to monitor and protect the distribution of any of your sensitive private health information. We will not, without your consent, share any private health information with others. We may use or disclose health information about you when contacting you to remind you of a dental appointment or to discuss finances. We may contact you by using a letter, voicemail, text or e-mail. To see the complete HIPAA compliance statement, see our front desk.

Consent of Health Information

In the event that I, _____, cannot accompany my child to their dental visit I give consent for the following individuals to accompany them. Additionally, I give consent for the listed individuals to sign for any scheduled treatment.

1.
2.
3.

I understand that if any of the above information changes, it is my responsibility to notify the staff of My Kids' Dentists.

**Note: If your child is sixteen (16) years of age or older and will be attending their appointment alone or any person(s) not listed above will be accompanying them, please send a signed note allowing for consent.*

**Any child under the age of eighteen (18) MUST be accompanied for any treatment appointments. This does not include cleanings and exams.*

Acknowledgement

I acknowledge that I have read and understand the above information. I hereby authorize My Kids' Dentists to release any medical information required for payment or insurance claims review. I understand and agree with above statements.

_____ _____

Parent/Guardian Signature Date

My Kids' Dentists

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information (PHI), to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. **This Notice takes effect 9/10/2013** and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health Information for your treatment. For example, we may disclose your health Information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health Information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Telephone:	Office: (770) 926-3400 Fax: (770) 926-6317
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E-mail:	info@mykidsdentists.com