Pediatric Dentistry of Round Rock

PATIENT CONSENT FORM/

HIPAA COMPLIANCE

Out Notice of Privacy Practices provides information about how we may use and disclose protected health information about you or your child. This notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you or your child is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you or your child for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made due to your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Policies and the parent/guardian of the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The parent/guardian of the patient has the right to restrict the use of their information, but the practice does not have to agree to those restrictions.
- The parent/guardian of the patient may revoke this consent in writing at any time, and all future disclosures will then cease.
- The parent/guardian of the patient gives authority to send dental records to other dentists via electronic means (email).

This consent was signed by:_____

Signature of Parent or Guardian

Relationship to patient (if other than parent):_____

Date:_____

Witness:_____

Pediatric Dentistry of Round Rock Financial Policy
Dr. Sage Thames

We are delighted to have your child as a patient. We look forward to keeping your child in tip top dental health and watching them grow over the years. Our office policies and financial agreement is listed below. If you have any questions we would be happy to answer them.

Appointments

It is very important that we receive 24 hour notice in the event that you need to cancel an appointment. We reserve time especially for your child, and have prepared in advance for your dental appointment. If you cancel with less than 24 hour notice, you will be charged a **$25.00 fee**.

Please be on time for your reserved appointments. If you are 15 or more minutes late for your appointment it will be considered a "no show" and will need to be rescheduled in order to have adequate time for your child's care.

(Initials_____)

Insurance

As a courtesy to you, we will be happy to file your **primary** dental insurance. As an open access practice we can file all PPO plans as a "non-contracted" provider. PPO plans have both in and out of network benefits. **Estimated patient out-of-pocket amounts and deductibles are due and payable at the time of service**. The benefits quoted are not a guarantee of payment and benefits not paid by the insurance company are the responsibility of the patient. In the state of Texas, insurance companies have up to 30 days to process a claim. If your insurance carrier has not responded in that time, we will contact you to keep you updated on your claim's status and may ask you to call your insurance company.

(Initials_____)

Office Policy and Payment Responsibility

Our office makes every effort to verify your benefits before treatment. We can only estimate what your insurance will cover and any financial limitations they may place on our services. We will strive to estimate your insurance's benefits and limitations; however, you may receive a statement or reimbursement after your claim has been processed. Regardless of who provides the dental insurance for the child, the parent/guardian **who signs the treatment consent** is responsible for payment.

(Initials_____)

Treatment Deposit

If your child's treatment includes sedation, a deposit of $325.00 is required to schedule the appointment. The deposit is non-refundable if the appointment is cancelled without giving 24 hour notice. Larger treatment cases also may require a deposit. The deposit money will be applied to your overall treatment cost.

(Initials_____)

Payments

- Payment is due when services are rendered. An estimate of your child's treatment fees will be outlined in detail with you at the time of your initial visit, or at a follow up treatment consultation.
- We accept Visa, MasterCard, Discover, American Express, cash and personal checks with proper identification.
  (Returned checks may be recovered electronically along with a state allowed recovery fee.)
- If financing is needed, we offer that through an outside company called **Care Credit** and will be happy to explain the terms. Please ask our front desk personnel for more information.

(Initials_____)

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Parent or Responsible Party's Signature_____Date_____