PEDIATRIC DENTISTRY CONSENT for DENTAL PROCEDURES and ACKNOWLEDGEMENT for RECEIPT of INFORMATION

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. At each examination appointment we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application or fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, caps, extractions, etc. will be performed at a separate appointment after obtaining your permission.

State Law requires that we obtain your written informed consent for any treatment given your child as a legal minor. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain further.

1. I hereby authorize and direct Dr. Andrew M Heaton/Dr. Alison D Campbell assisted by other dentists and/or dental auxiliaries of their choice, to perform upon my child the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

2.In general terms the dental procedures or operations will include:
A) Cleaning of the teeth and the application of fluoride.
B) Application of Sealants to the grooves of the teeth.
C) Treatment of diseased or inured teeth with dental restorations. (fillings or crowns)
D) Replacement of missing teeth with dental prosthesis.
E) Removal (extraction) of one or more teeth.
F) Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
G) Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 1 ½ - 3 hours. Allergic reactions are rare. Your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child they are going to get a "shot." We have a special way of informing them of this.
H) Use of behavior management techniques.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage or death. I further authorize Dr. Andrew M. Heaton/Dr. Alison D Campbell and Associates to perform treatment as may be advisable to preserve the health and life of my child.

I hereby state that I have read and understand this consent and the behavior management techniques on page 4 (if applicable) and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that this consent will remain in effect until such time that I chose to terminate it.

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Patient Name:

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Signature of Parent or Guardian: Date:

BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental operatory shall be the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity and resistive movements. Refusing to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or the sharp dental instruments.

All efforts will be made to obtain the cooperation of the child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

1) Tell-show-do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

2) Positive reinforcement. This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.

3) Voice Control: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.

4) Mouth props: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.

5) Sedation: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. These drugs may be administered orally. The child does not become unconscious. Your child will not be sedated without you being further informed and obtaining your specific consent for such procedure.

6) General anesthesia: The dentist performs the dental treatment with the child anesthetized in the hospital operating room.

Your child will not be given general anesthesia without your being further informed and obtaining your specific consent for such procedure.

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Patient Name:

Initials: _____ Date: _____

Lakeside Children's Dentistry Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to your child and regard your complete understanding of our financial policies as an essential element of care and treatment.

• Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we will accept cash, check, visa, master card, discover and American Express. The **adult accompanying** the child is responsible for payment for services rendered to a child patient.

• Your insurance is a contract between you and your insurance company. As a courtesy, after your first initial visit and upon verification of coverage, we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

• We are contracted with MOST dental insurance plans. If you are covered by one of these plans, we will bill your plan and will only require you to pay your estimated co-payment at the time of service. Any remaining balance would be due upon receipt of our statement. We also accept Traditional Medicaid and Texas Chips, as well as Delta Dental, MCNA and Dentaquest Medicaid and Chips plans, including the Star program.

• All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be "not covered" or over what they deem "usual and customary charges" you will be responsible for this amount. Payment is due upon receipt of statement from our office. If payment is not made upon receipt of our statement, we will no longer file your insurance. Therefore, we will expect payment in full at the time of service. We do honor some Discount Dental plans so please ask our front office staff to see if we accept your plan.

• Your estimated portion of our fees for scheduled hospital procedures is due when scheduling the surgery date. Any balance remaining after your dental plan pays is your responsibility and payment is due upon receipt of statement from our office.

• Missed/Late Appointment(s) Policy – Although, we make every attempt to remind you of your scheduled appointment, it is your responsibility to remember all appointment date(s)/time(s). The doctors have reserved this time, especially for you and your child to meet their dental needs. Cancellations require a 24 hour prior notice, or your account may be assessed a $25 missed appointment fee. Late arrivals (more than 15 minutes) may require rescheduling your child to another day. Please be on time so the doctor can provide the best treatment for your child. _____(Initial) I have read and understand**.**

I have read and understand the financial policy of the practice, and I agree to be bound by its terms.

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Patient Name:

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Signature of Parent or Guardian: Date:

Authorization for Release of Health Information

I authorize Dr. Andrew M Heaton/Dr. Alison D Campbell and Associates to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to my child/children that is needed to review, investigate or evaluate any claim for benefits, as well as for continuity of care.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or a similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Dr. Andrew M Heaton/Dr. Alison D Campbell and Associates to submit claims for payment for services to healthcare service plans or insurance companies named below, on my behalf and in my name, and assign to Dr. Andrew M Heaton/Dr. Alison D Campbell the groups insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for covered services.

Name of Insurance Company/Companies

1. _____(Primary)

2. _____(Secondary)

This authorization shall remain effective for up to five years from this date. I know I have a right to receive a copy of this authorization if requested.

I also understand that although Dr. Andrew M Heaton and Dr. Alison D Campbell strive to give the most accurate insurance information possible with regards to my plan, it is ultimately my responsibility as the insured/subscriber to know and understand my benefits, limitations and exclusions of my individual policy.

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Patient Name:

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Signature of Parent or Guardian: Date:

LAKESIDE CHILDRENS DENTISTRY

Andrew M Heaton, D. D. S./ Alison D Campbell, D. D. S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

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Patient Name:

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Signature of Parent or Guardian: Date:

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prevented us from obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

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may be