Patient Name: _____ _____

Date of Birth: _____

GENERAL CONSENT & ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

It is the policy of PEDIATRIC DENTAL CENTER OF GARDENS INC to provide their prospective patients with information regarding the treatment or procedures they are recommending.
Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's oral health treatment after considering the risks, benefits, and alternatives.
Please read this form carefully and ask about anything you do not understand. We will be pleased to further explain it to you.

Authorization for Dental Treatment

I hereby authorize and direct the Doctors at PEDIATRIC DENTAL CENTER OF GARDENS INC, assisted by dental auxiliaries of their choice, to perform upon my child (or legal ward for whom I am empowered to consent) the following dental treatment or oral surgery procedure(s):

- Examination and radiographs (X-rays) as determined by the dentist
- Cleaning of the teeth and application of topical fluoride
- Application of "sealants" to the fissures or grooves of the teeth
- Administration of local anesthetics
- Treatment of diseased or injured teeth with dental restorations (fillings, crowns and pulpotomies)
- Removal (extractions) of one or more teeth
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Replacement of missing teeth with space maintainers and/or dental prosthesis
- Treatment of malposed ("crooked") teeth and/or oral developmental or growth abnormalities
- Use of behavioral guidance techniques and/or protective stabilization
- Use of sedative drugs to control apprehension and/or disruptive or pre-cooperative behavior
- Use of general anesthesia with an anesthesiologist to accomplish the necessary treatment

This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages, disadvantages, and risks of each. These include:

- Pain and/or sensitivity to temperature changes
- Spontaneous pain
- Abscess
- Fracture of the tooth away from the restoration
- Partial or complete loss of the restoration
- Restoration failure and/or loosening of the crowns necessitating their replacement or re-cementation

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee either expressed or implied, as to the result of the treatment or as to the cure.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well-being in the professional judgment of the Doctors of PEDIATRIC DENTAL CENTER OF GARDENS INC.

Pediatric Behavior Management Techniques

It is our intent that all professional care delivered in our offices shall be of 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
- Resistive movements
- Refusing to open the mouth or keep it open long enough
- Aggressive or physical resistance (kicking, screaming, grabbing instruments or dentist's hands)

All efforts will be made to obtain cooperation using warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

Common Techniques Used in this Office:

- **TELL-SHOW-DO**: The dentist or assistant explains to the child what is to be done using simple age-appropriate terminology. Secondly, the child is shown the procedure on a model or on the finger of the dentist or assistant. Lastly, the procedure is performed as described.
- **POSITIVE REINFORCEMENT & DESCRIPTIVE PRAISE**: Praise is given to the child to reinforce cooperative behavior. Desirable behavior is acknowledged to encourage its

recurrence.

- **VOICE CONTROL**: A deliberate alteration of voice volume, tone, or pace to influence and direct the patient's behavior.
- **DISTRACTION**: Diverting the patient's attention from what may be perceived as an unpleasant procedure.
- **MOUTH PROPS**: A rubber or similar device is placed in the child's mouth to prevent closing and possible injury when a child refuses or has difficulty keeping the mouth open.
- **PHYSICAL RESTRAINT BY THE DENTIST/DENTAL ASSISTANT/PARENT**: The dentist, assistant (under direction), and/or parent may help restrain the child from movement by holding the child's hands, stabilizing the head, and/or controlling leg movements or providing security by holding the child in the parent's lap.
- **PAPOOSE BOARD AND PEDI-WRAP**: These are restraining devices used to limit disruptive movements and prevent injury, enabling the dentist to provide the necessary treatment. The child is wrapped in one of these devices placed on a reclined dental chair.
- **NITROUS OXIDE-OXYGEN GAS**: The child remains conscious but may become drowsy or fall asleep. No sedation will occur without further explanation and specific consent.
- **SEDATION**: Various drugs are used to relax a child who does not respond to other techniques or cannot cooperate due to age or maturity. Administered with Nitrous Oxide-Oxygen gas and with specific consent.
- **GENERAL ANESTHESIA**: A medically induced state of unconsciousness allowing dental rehabilitation in a hospital, ambulatory, or dental office setting. Not provided without further explanation and consent.

I have read and understand the listed pediatric dentistry behavior management techniques and alternative techniques.
All questions about the behavior management techniques described have been answered in a satisfactory manner.

Acknowledgment of Receipt of Information and Risks

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 reactions to medication that could require hospitalization, additional surgical procedures, disability, systemic impairment, temporary or permanent nerve damage, brain damage, or death.

I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia, sedation, general anesthesia, and medications. The most common include:

- Swelling
- Bleeding

- Pain
- Nausea or vomiting
- Bruising
- Tingling and/or prolonged numbness of the lips, gums, face, or tongue
- Allergic reactions
- Hematoma (swelling)
- Fainting
- Lip and cheek biting resulting in ulceration or infection of the mucosa

I also understand there are rare but serious risks such as unfavorable reactions to medications, including respiratory and cardiovascular collapse (cessation of breathing or heart function) and lack of oxygen to the brain that may result in coma or death.

Authorization for Records and Use of Images

I authorize my pediatrician and/or any other physicians or medical facilities to release any and all pertinent medical information regarding my child.
I also authorize the Doctors at PEDIATRIC DENTAL CENTER OF GARDENS INC to use photographs, radiographs, diagnostic materials, and treatment records for the purposes of teaching, research, and scientific publications.

Financial Responsibility and Consent

I understand that the treatment plan and estimated fees presented may change depending on the time elapsed since the initial examination and the extent of decay.

I accept full responsibility for payment of all services rendered, including charges not covered by insurance, state agencies, or other payers. I acknowledge I am also responsible for any collection fees in the event the account becomes delinquent.

I authorize the release of pertinent information to individuals or organizations who may require it for the continuation of treatment, payment of services rendered, or credit referencing.

Final Acknowledgment

I certify the accuracy of the information provided.
I acknowledge that I have read and understood this consent. All questions regarding the recommended treatment, procedures, and behavior management techniques have been answered to my satisfaction.
I understand I have the right to receive further clarification during the course of my child’s care and that I have not been coerced into signing this form.
I am aware that I may withdraw this consent at any time, and it will remain in effect until such withdrawal is submitted.

I hereby authorize and direct the Doctors of PEDIATRIC DENTAL CENTER OF GARDENS INC to perform upon my child (or legal ward), if required, the necessary behavior management techniques to facilitate the provision of recommended dental treatment.

Member Financial Responsibility

Thank you for choosing PEDIATRIC DENTAL CENTER OF GARDENS INC as your provider.

Understanding Your Financial Responsibility

The dental services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form.

Feel free to ask if you have any questions regarding your financial responsibility.

Your Responsibilities

You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for:

- Deductibles
- Co-payments
- Coinsurance amounts
- Any other patient responsibility indicated by your Children Dental insurance carrier

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Knowledge of Your Dental Insurance Policy

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply:

I. Your Dental plan requires referral by a Primary Dental Physician (PDP) before receiving services at PEDIATRIC DENTAL CENTER OF GARDENS INC, and you have not obtained such a referral
II. You receive services in excess of such authorization or referral
III. Your Dental plan determines that the services you received at PEDIATRIC DENTAL CENTER OF GARDENS INC are not medically necessary and/or not covered by your insurance plan
IV. Your Dental plan coverage has lapsed or expired at the time you receive services at PEDIATRIC DENTAL CENTER OF GARDENS INC
V. You have chosen not to use your Dental plan coverage

If you are not familiar with your plan coverage, we recommend you contact your Dental carrier or plan provider directly.

Registration and Insurance Verification

You will be required to follow all registration procedures, which may include:

- Updating or verifying personal information
- Presenting verification of current insurance
- Paying any co-pays or other patient responsibility amount at each visit

Your card or other insurance verification must be on file for your insurance to be billed.
If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a **self-pay patient**.
As a self-pay patient, our fee is expected to be paid **in full at the time of service**.

If the insurance card or other necessary information is furnished **after** the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed.

If you are not prepared to make your co-pay or other patient responsibility amount, **your visit may be re-scheduled by PEDIATRIC DENTAL CENTER OF GARDENS INC**

Insurance Billing and Claim Authorization

We may verify your insurance benefits or submit your claim to your insurance carrier as a **courtesy** to you.
You agree to facilitate payment of claims by contacting your insurance carrier when necessary.

Without waiving any obligation to pay, you assign to PEDIATRIC DENTAL CENTER OF GARDENS INC, for application onto your bill for services, **all of your rights and claims for the dental benefits** to which you or your dependents are entitled, under:

- Any federal or state dental plan (including, but not limited to, Medicaid)
- Insurance policy
- Any managed care arrangement
- Or other similar third-party payor arrangement

This includes **coverage for dental care costs and for which payment may be available to cover the cost of the services provided to you**.

Authorization to Release Information

You authorize PEDIATRIC DENTAL CENTER OF GARDENS INC and associated physicians, staff, and hospitals to release patient information acquired in the course of your examination and/or treatment, including but not limited to:

- Any and all Dental records
- Notes
- Test results

- X-ray reports
- Other documents related to your treatment

This release is deemed necessary to process your claim to the necessary insurance companies, third-party payors, and/or other physicians or dental care entities as they require to participate in your care.

It is important to notify us as soon as possible of any changes related to your insurance coverage.
Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim.

PEDIATRIC DENTAL CENTER OF GARDENS INC does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

Timely Payment and Balance Resolution

If your Dental insurance carrier does not remit timely payment on your claim, **you will be responsible for payment of the charges** within the terms set forth herein.

Once your insurance carrier processes your claim, we will bill you for **any remaining patient responsibility** deemed by your insurance carrier.

If any payment is made **directly to you** for services billed by us, **you agree to promptly submit same to PEDIATRIC DENTAL CENTER OF GARDENS INC until your patient account is paid in full**.

HIPAA NOTICE OF PRIVACY

Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your **protected health information (PHI)** to carry out treatment, payment, or healthcare operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

Definition of Protected Health Information (PHI)

“Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical, dental, or mental health or condition and related dental or health care services.

Your protected health information may be used and disclosed by your dentist, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of:

- Providing health care services to you
- Paying your health care bills
- Supporting the operation of the dentist’s practice
- Any other use required by law

Uses and Disclosures of PHI

We will use and disclose your protected health information to:

- Provide, coordinate, or manage your health care and any related services (including coordination with a third party)
- Obtain payment for your dental care services
- Support business activities of your dentist’s practice, including (but not limited to):
    - Quality assessment activities
    - Financial and/or billing audits
    - Employee review activities
    - Licensing
    - Participation in managed care plans
    - Defense of legal matters
    - Conducting or arranging other business activities

Examples of routine uses and disclosures include:

- A sign-in sheet at registration, where you may be asked to sign your name and indicate your dentist
- Being called by name in the waiting room when your dentist is ready
- Appointment reminders via phone, text, email, or written notices
- Notifications about other treatments or services at our office that may benefit you

  Unless you tell us otherwise, we may contact you or someone who answers your phone through any of the above communication methods.

Disclosures Without Authorization

We may use or disclose your PHI **without your authorization** in the following situations:

- As required by law
- Public Health issues

- Communicable Diseases
- Health Oversight
- Abuse or Neglect
- FDA Requirements
- Legal Proceedings
- Law Enforcement
- Coroners, Funeral Directors, Organ Donation
- Research
- Criminal Activity
- Military Activity and National Security
- Workers' Compensation
- Inmates
- Required Uses and Disclosures per Section 164.500 and the Secretary of Health and Human Services

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Other Uses Requiring Authorization

Other permitted and required uses and disclosures will be made **only with your consent, authorization, or opportunity to object**, unless required by law.

> You may revoke this authorization **in writing**, at any time, except where actions have already been taken in reliance on it.

Your Rights Regarding PHI

You have the following rights with respect to your protected health information:

1. Right to Inspect and Copy

You may inspect and copy your PHI, with some exceptions (e.g., psychotherapy notes, information compiled for legal proceedings, or as restricted by law).

2. Right to Request Restrictions

You may ask us **not** to use or disclose part of your PHI for treatment, payment, or healthcare operations, or to certain family/friends.
Your request must include the specific restriction and to whom it applies.

> Your dentist is **not required** to agree to your request. If denied, you may choose another Dental Care Professional.

3. Right to Confidential Communications

You may request to receive communications by alternative means or at alternative locations.

4. Right to a Paper Copy

You have the right to obtain a paper copy of this notice at any time, even if you received it electronically.

5. Right to Amend Your PHI

If your PHI is incorrect or incomplete, you may request an amendment.
If denied, you may file a **statement of disagreement**, and we may respond with a **rebuttal**, which you will receive a copy of.

6. Right to an Accounting of Disclosures

You have the right to receive an accounting of certain disclosures we have made of your PHI.

Changes to This Notice

We reserve the right to **change the terms of this notice** and will notify you by mail of any changes.
You then have the right to **object or withdraw** as provided in this notice.

Complaints

If you believe your privacy rights have been violated:

- You may **complain to us**
- You may file a complaint with the **U.S. Department of Health and Human Services, Office for Civil Rights**

  We will **not retaliate** against you for making a complaint.

To complain to us, submit your complaint **in writing** to the office contact person at the address, fax, or email of the office where you received care.
You may also speak with us **in person or by phone**.

Appointment Reminders and SMS Communications

As part of our commitment to your care, Pediatric Dental Centers may contact you regarding your appointments and related services.

By providing your contact information, you expressly consent to receive communications from Pediatric Dental Centers, including appointment reminders and service-related notifications, via phone call, email, and SMS (text message), including messages sent using an automatic telephone dialing system or other automated technology.

You understand that your consent to receive such communications is not a condition of receiving treatment or services from Pediatric Dental Centers.

SMS messages may include appointment reminders sent approximately one week prior to your scheduled appointment and again one day before your visit. Additional messages may be sent if multiple appointments are associated with your phone number or if updates or changes to your appointments occur.

Message frequency may vary depending on your scheduled appointments and interactions with our office.

You may opt out of receiving SMS messages at any time by replying **STOP** to any message. For assistance and and **HELP** contact our office directly (786) 410-3018.

We respect your privacy. Your mobile information will not be shared with third parties or affiliates for marketing or promotional purposes. We may share your information with service providers as necessary to deliver these communications or as required by law.

For More Information

Contact us at:

- Phone: **(305)4540911**
- Visit: **18244 Nw 27th Ave Miami Gardens FL 33056**
- Fax: **(786)3206281**
- Email: **gardens@pediatricdentalcenters.com**

Acknowledgment and Consent

I acknowledge that I have received and agree to the General Consent & Receipt of Information, Member Financial Responsibility, and the HIPAA Notice of Privacy Practices.

Patient Signature