



Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____ Date: _____

Information to be used or disclosed:

The information covered by this authorization includes but is not limited to: Treatment planning, condition of teeth and surrounding structures, health history, and account activities, treatment performed including changes in treatment.

Persons to Whom Information May Be Disclosed

Information regarding my child's protected health information to carry out treatment, payment activities, and healthcare operations (i.e. grandparent, aunt, uncle, step-parent): Please list below:

Expiration Date of Authorization

This authorization is effective through the following dates ___/___/___ or indefinitely, unless
(Circle One)

revoked or terminated earlier by the parent/legal guardian.

Right to terminate or revoke authorization

You may revoke or terminate this authorization by submitting a written revocation to the practice.

Potential for re-disclosure

Information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state law.

I, _____, Mother/Father/Legal Guardian have had full opportunity to read
Printed Name (Circle One)

this disclosure authorization and consent form and your Notice of Privacy Practices. I understand that by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operation.

Signature: _____ Date: _____



FINANCIAL POLICY

Thank you for choosing Dr. Keysra M. Washington as your child's dental care provider. Our greatest concern is your child's complete oral health. Anything we do or say will be centered on that philosophy. It is suggested that each patient is seen every six months (or as needed) to ensure this preventive philosophy is met. We are committed to your treatment being successful, and to the return and maintenance of your child's good oral health. Please understand that payment of your child's bill is considered part of that treatment. The following is a statement of our **Financial Policy**, which we ask you read and sign prior to any treatment.

PAYMENT FOR SERVICES RENDERED: Patient's parent or guardian is responsible for payment of all services rendered on the behalf of their dependents. Payment is due at the time of service. If there is a third-party involved (other than insurance), those arrangements **must** be made prior to your child's treatment. We accept cash, checks, MasterCard, Visa, Discover, American Express and Care Credit.

INSURANCE ASSIGNMENT: Most insurance plans do not pay 100% of the fees charged and have a deductible, which must be satisfied before any insurance benefits can be received. Also, please keep in mind that some, and perhaps all, of the services are not considered **reasonable and customary** under the provisions of your insurance plan. In most cases you will be charged the difference in our fee and what your insurance allows. We require that all deductibles, co-pays, and/or any percentage of the bill that the primary insurance carrier does not cover, be paid at the time of service. **Your insurance policy is a contract between you and your insurance company. We are not a party to that company's assignment.** If your insurance company has not paid your balance in full within 90 days, the balance will automatically be transferred to your account, and you will be responsible for the balance owed. **This office cannot render services on the assumption that our fees will be paid by your insurance company.**

INSURANCE FACTS: Most insurance companies have a yearly deductible. You will need to know what your deductible is and pay that amount before your insurance company will begin to pay benefits.

DEFAULT ON PAYMENT: In the event of default on payment, the Parent/Guardian promises to pay a service fee in the amount of **\$25.00** in addition to the balance owed.

Patient Name: _____

Responsible Party Signature: _____ Date: _____

Print Responsible Party Name: _____



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.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2006, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or other healthcare operations, you may give us written authorization to use our health information or to disclose it to any one for any purpose. If you give us an authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Right section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of our incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice, to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuses or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim or abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letter).

PATIENT RIGHTS

Access: You have the right to request copies of your health information with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternate means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

Contact Information:

Dr. Keysra M. Washington, D.D.S.
1400 Dogwood Drive, S.E.
Conyers, GA 30013



**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

“You May Refuse To Sign This Acknowledgment”

I, _____ have read and understand this office’s Notice of Privacy Practices.

Patient’s Name(s)

Parent/Guardian Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient’s Name(s): Same As Above

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about our protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Parent/Guardian Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

(Include completed Consent in the patient’s chart).



Office Policies and Consent to Dental Treatment

Our office is dedicated to improving the oral health of your child. Through education, prevention, and intervention, we can accomplish these goals. We encourage you to take an active role in your child's oral health. The American Academy of Pediatric Dentistry has published guidelines which our office is committed to following. In accordance with those, recommendations may be made relevant to your child's level of risk for getting cavities. **It is imperative that you notify our office of any change in your child's health.** We also encourage you to let us know of any extenuating circumstances in your child's life so we can better care for your child. By signing this form, you acknowledge that you understand that today's treatment may include the following treatments:

Complete Exam including Radiographs;

Limited Emergency Exam including Radiographs;

Dental Cleaning (Toothbrush or rubber cup prophylaxis with prophylaxis paste);

Fluoride Varnish (Proven to be effective in reducing dental decay)

Oral Hygiene Instructions and Diet Counseling

Teen Counseling (habits, drug use, tobacco, other high risk behaviors that have dental consequences)

Dental Treatment

Sometimes, one or more of the above treatments may not be able to be obtained due to pre-cooperative behavior or anxiety. We make every attempt to make your child feel comfortable, welcome, and relaxed. Our doctors and staff are highly trained in behavior guidance techniques that will help your child in the dental setting. These include:

Positive Reinforcement

Tell – Show – Do: This is a technique, in which we first tell your child about a procedure, then we show them the procedure either on a model or stuffed animal, then we do the procedure.

Distraction: This can be a very effective tool for the anxious child. Televisions, redirecting the conversation or other aids may be used.

Parental Absence or Presence: We encourage you to accompany your child into the treatment area. Most children do well with the parent/guardian present. On occasion, a child may be more attentive to the dentist/staff when parents are not present. Parents may be asked to step into the hallway or into the waiting room in order to obtain cooperation. This is used only in special/extenuating circumstances. Most children are comfortable coming to the treatment area without a parent. There may be times when we may ask parents to come into the treatment area if we need assistance in gaining assistance in gaining cooperation or communication with your child.

Nitrous Oxide: This is a pharmacologic aid to help relax your child. It is very safe and effective. It is administered to help children reduce anxiety and it also helps relax the gag reflex. This is an immediate acting sedative and only works while the child is breathing it through his/her nose. Once 100% oxygen is given at the end of the appointment, it is no longer effective and there is no prolonged sedation/effect. Nitrous Oxide works best for children who have a clear airway and can breathe through their nose. A child who has a

congested airway may not feel the full effect of the agent. This main documented side effect is nausea. Some children may experience nausea with nitrous oxide. To reduce this side effect, we encourage parents to only give their child a light meal before the dental appointment.

Protective stabilization: We do not routinely provide physical restraint in this office. Special circumstances may arise where a child could be injured by raising their arms or moving their head. To provide the safest treatment, the dentist or staff may gently hold their head or arms away from the equipment/dental instruments being used. Sometimes we encourage parents to aid in holding their child still to complete a procedure.

By signing this form, you are stating that you are the child's parent or legal guardian, and you understand that some or all of the procedures listed above may or may not be performed today or in subsequent visits. You are acknowledging that the dentist may make decisions in the best interest of your child. In regard to behavior management techniques, any or all of the above listed techniques may be used to help your child have a safe and positive experience.

Child: _____ Parent/Guardian _____ Date _____



Mini Smiles Pediatric Dentistry

Patient Name (Last, First, Middle) _____
Date of Birth _____ Goes by: _____
Age: _____ Male/Female _____

Home Address – Street _____

City _____ State _____ Zip Code _____

Home # _____

Patient resides with: Mother ___ Father ___ Both ___ Guardian _____

Married ___ Divorced ___ Separated _____

If Guardian, do you have legal custody? Yes ___ No ___

Is he/she adopted? Yes ___ No ___

Siblings that we see? _____

MOTHER Last _____ First _____

Mother's address – Street _____

City _____ State _____ Zip Code _____

SS# _____ DOB _____

Mother's Cell # _____ Work # _____

Email _____ DL# _____

Mother's Employer/Occupation _____

FATHER Last _____ First _____

Father's address – Street _____

City _____ State _____ Zip Code _____

SS# _____ DOB _____

Father's Cell # _____ Work # _____

Email _____ DL# _____

Father's Employer/Occupation _____

Whom may we thank for referring you to our office? _____

Who is accompanying the child today? _____

Who is responsible for the patient's account? _____

Responsible Party Name _____

Address _____ City _____ State _____ Zip _____

Home# _____ Cell# _____ Work # _____

Email _____

DENTAL INSURANCE:

Insurance Company Name _____

Address _____

Phone # _____

Group# _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's DOB _____

SS# _____

Policy Owner's Employer _____

DENTAL HISTORY:

When was your child's last dental visit? _____

What is your main concern today? _____

Has your child ever had a negative dental experience? _____

Brushing? Once Daily Twice Daily

Flossing? Once Daily Twice Daily

Thumb Habit? Yes No Pacifier? Yes No

Previous Orthodontic Treatment? Yes No

Does your child drink Well Water? Yes No

Does your child wear a mouth guard for sports? Yes No

HEALTH HISTORY

Does your child have any of the following?

- Y N **Asthma (circle)** Mild Moderate Severe
- Y N **ADD** or **ADHD**
- Y N **Allergies** (seasonal)
- Y N **Allergy** (Drug) _____
- Y N Allergy to Latex products
- Y N Diabetes
- Y N Drug or Tobacco Use
- Y N Cancer
- Y N Seizure Disorder
- Y N Heart Murmur
- Y N Bleeding Problems
- Y N Syndrome _____
- Y N Shunt Placement
- Y N Kidney Problems _____
- Y N Liver Problems _____
- Y N Hearing Impairment
- Y N Blindness
- Y N Hepatitis
- Y N HIV / AIDS
- Y N Reflux
- Y N GI problems
- Y N Eczema
- Y N Anorexia or Bulimia
- Y N Thyroid Disease
- Y N Spina Bifida
- Y N Brain Tumor
- Y N Developmental Delay
- Y N Depression
- Y N Anxiety
- Y N Bipolar Disorder

- Y N Asperger's
- Y N Autism
- Y N Speech Therapy or Occupational Therapy
- Y N Cerebral Palsy
- Y N Pregnancy
- Y N Birth Control Pills
- Y N Congenital Heart Defect
- Y N Sickle Cell Anemia
- Y N Sickle Cell Trait
- Y N Thalassemia
- Y N Piercings
- Y N Handicaps or Disability _____

List any other Medical Problems or Specific Diagnosis:

List All Previous Surgeries:

List All Medications patient is CURRENTLY taking:

List All Medications patient is allergic to: (rash/hives):

Help us get to know your child better:

What are your child's interests? _____

What motivates your child? _____

Is your child fearful in the dental setting? Yes _____ No _____

What dental procedures has your child had previously? (Circle all that apply)

- Cleaning
- X-rays
- Nitrous Oxide
- Sedation
- Filings/crowns
- Sealants
- Extractions

Are there any specific fears your child has? _____

Is there anything we should know about your child?

Physician Name: _____

Physician Phone #: _____

Date of last Physical Evaluation: _____

Immunizations up to date? Yes _____ No _____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Parent/Guardian Signature

Date