

### Minor/Child Consent

I, being the parent or guardian of \_\_\_\_\_, do hereby request and authorize the dental staff to perform necessary dental services for my child, including x-rays, nitrous oxide (laughing gas), and administration of anesthesia and any services deemed advisable by the doctor, even if I am not present in the operatory during the dental treatment. \_\_\_\_\_ Initial

### Permission to Treat

Because your child is a minor it is necessary to have signed permission from a parent or guardian. The signature affixed below authorizes examination and treatment as necessary and the use of procedures the doctor may deem necessary during the performance of his services. Furthermore the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient. Photos and other dental records of my child may be used for teaching or instructional purposes. \_\_\_\_\_ Initial

### Dental Treatment

I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary. I consent to the use of photography for the purposes of future education and display of specific dental procedures performed by Amarillo Pediatric Dentistry. \_\_\_\_\_ Initial

### Financial Agreement

I acknowledge that payment is due in full at the time of treatment. I accept full responsibility for all fees and services rendered. Accounts past 60 days are subject to a \$50 rebilling fee. If your account becomes past due, we will refer to an agency to collect the debt. Returned checks will be charged a \$30 fee. \_\_\_\_\_ Initial

### Consent for use and disclosure of health information HIPPA PRIVACY POLICY

You have the right to read our Notice of Privacy Practices before you decide whether to sign the consent. I, \_\_\_\_\_, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. \_\_\_\_\_ Initial

### Acknowledgement of receipt of Notice of Privacy Practices

I, \_\_\_\_\_, have received a copy of this offices Privacy Practices. \_\_\_\_\_ Initial

### Insurance

I understand Amarillo Pediatric Dentistry does not bill third parties, including secondary insurance, medical/accidental insurance, or non-custodial parent(s). I understand Amarillo Pediatric Dentistry will file my primary insurance as a courtesy to me. \_\_\_\_\_ Initial

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to child: \_\_\_\_\_