HIPAA CONSENT FORM
From the office of: Children's Dental Health of Lynchburg

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. 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 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 for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on 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 (PHI) may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office. This will include, but not limited to, appointments day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

Please check all that apply, and write in appropriate information needed for contact.

__ Home Phone _____ __ Cell Phone _____
__ Home Email _____ __ Work Phone _____
__ Emergency Contact Name _____
__Emergency Contact Phone _____ __ Cell Phone _____
__Interpreter Contact Name _____ __ Phone _____

List names of who can have access to your dental/medical chart information:

This access will include : Financial, Treatment, Health history, is allowed to be disclosed or copied

_____ **Full Access/ Relation to Patient** _____
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_____ Patient gives office permission to forward any verified contact information and PHI to patients specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name: _____ **Date** _____

Print Legal Guardian's Name: _____ **Date** _____

Signature of Patient or Legal Guardian: _____ **Date** _____

____Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Office Staff Signature_____ **Printed Name**_____ **Date** _____

Children's
Dental Health
of Lynchburg

Specializing in Children, Teens, and Young Adults

Shannon M. Sawyer DMD Summer A. Sawyer DMD

We, at Children's Dental Health of Lynchburg, know how valuable your time is and we hope you feel the same about us. Consequently, we have a policy to protect our appointment schedule.

Sickness Policy

If your child is sick in anyway either the night before or the day of a scheduled appointment, or if you have an emergent situation, please call our office at your earliest convenience to reschedule.

Cancellation Policy

If you must cancel an appointment for other reasons, we require a call at least **24 hours** prior to your scheduled visit, so that we may accommodate other patients. If you fail to provide proper notice, you may be subjected to a **$35 cancellation fee**.

Missed Appointment Policy

A missed appointment is defined as simply failure to arrive at an appointment without providing notification. Patients who miss appointments may also be subjected to a **$35 missed appointment fee**.

Also, if a second appointment is missed during the same **12 month** period, we will no longer schedule appointments for that patient.

By signing this form, you acknowledge that you have read the policy, understand it, and accept it. You should also share this information with all persons who are responsible for bringing the patient to their visit.

Patient's Name_____

Signature_____ Date_____

Relationship to patient_____

Children's Dental Health of Lynchburg

NEW PATIENT QUESTIONNAIRE & CONSENT

CHILD'S FIRST NAME: _____ **MIDDLE INITIAL:** _____ **LAST NAME:** _____

Male: _____ **Female:** _____ **CHILD'S PERFERRED NAME:** _____

CHILD'S DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SSN#:** _____

HOME ADDRESS: _____
STREET CITY STATE ZIP

PARENT'S PRIMARY TELEPHONE NUMBER: _____

Names and ages of brothers and/or sisters, if any: _____

CHILD'S PHYSICIAN: _____

Is your child being treated for any medical issues at this time? **Yes/No** If Yes, please explain: _____

_____

Is your child taking any prescription medications? **Yes/No** If Yes, list the medication and the medical condition:

_____

_____

ALLERGIC REACTION: Does your child have any allergies or has had an allergy to any medicine or anesthetic? Yes/No

If Yes, please explain _____

Does your child have any of the following? (Circle appropriate answer)

HEART DISEASE	YES	NO	ARTHRITIS	YES	NO
HEART MURMUR	YES	NO	LOSS OF CONSCIOUSNESS	YES	NO
RHEUMATIC FEVER	YES	NO	FAINTING	YES	NO
KIDNEY PROBLEMS	YES	NO	SEIZURES	YES	NO
LIVER DISEASE	YES	NO	EMOTIONAL PROBLEMS	YES	NO
HEPATITIS	YES	NO	CEREBRAL PALSY	YES	NO
HIV (AIDS) VIRUS	YES	NO	SPEECH DIFFICULTIES	YES	NO
MALABSORPTION SYNDROME	YES	NO	ADD/ADHD	YES	NO
PROLONGED BLEEDING	YES	NO	AUTISM	YES	NO
ASTHMA/BRONCHITIS	YES	NO	OTHER		
RESPIRATORY PROBLEMS	YES	NO	OTHER		
DIABETES	YES	NO	OTHER		

Has your child ever been hospitalized? Yes/No If yes, please explain _____

_____

DENTAL HISTORY

YES	NO	
____	____	1.) Is this your child's first dental visit?
____	____	2.) Does your child have a toothache or any dental problems? _____
		_____
____	____	3.) My child sucks his or her thumb/fingers?
____	____	4.) My child has other habits affecting his or her teeth? Explain_____
____	____	5.) Do you feel your child is getting their teeth brushed properly every day?
____	____	6.) Do you have any objection to taking diagnostic x-rays of your child's teeth?
		If Yes, please explain. _____
____	____	Would you like sealants (cavity protectors) on your child's permanent molars if insurance covers the treatment? *Note: your child must be at least 5 years old*

Who was your child's previous dentist? _____ Date of last visit: _____

Father's Name: _____ Home Phone: _____ Cell Phone: _____

Father's SSN: _____ Employer: _____

Mother's Name: _____ Home Phone: _____ Cell Phone: _____

Mother's SSN: _____ Employer: _____

In order to keep our fees reasonable, we do not bill for services rendered. Our policy is that you pay as services are rendered. Please check appropriate Dental Insurance Plan you wish to use:

NO INSURANCE _____ PRIVATE INSURANCE _____ MEDICAID _____

For private insurance only, please provide the following policy holder's information:

Policy Holder: _____ **DOB**: _____ **SSN#:** _____

Employer: _____ **Dental Insurance Carrier**: _____

CONSENT:

Your child is a minor, therefore, it is necessary that a signed consent be obtained from a parent or guardian before any necessary dental service can be started. I grant Children's Dental Health of Lynchburg permission to provide my child's dental exam and treatment, and I will be responsible for the cost of this dental care.

Signed: _____

(parent or guardian) **Date**

By signing this agreement, I understand that I am responsible for ALL fees incurred by services performed by Children's Dental Health of Lynchburg. I also understand that is my account balance becomes delinquent at any time, the outstanding amount can/will be transferred to a collection agency/attorney for recovery of this debt. If that occurs, I understand I will be charged interest in the amount of 24% annually, collection and/or reasonable attorney fees and any court cost fees which may occur with the collection of this amount due.

Signed: _____ Witness: _____