Permission to Treat

Due to your child being a minor it is necessary to have signed permission from a parent or legal 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. I give the permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. 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 the office of any changes in my child's health status.

Parent/Legal Guardian (type name): __________________________ Relationship: __________________________ Date: __________

Minor/Child Consent

I, being the parent or legal guardian of __________________________, do hereby request and authorize the dental staff to perform necessary dental service 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 here: _____

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.

Initial here: _____

Financial Agreement/Insurance

I understand that Amarillo Pediatric Dentistry and Orthodontics is out of network with ALL insurance companies. I understand that Amarillo Pediatric Dentistry does not bill third parties, including secondary insurance, medical/accidental insurance, or non custodial parent(s). I understand that Amarillo Pediatric Dentistry will file my primary insurance as a courtesy to me. I also understand that payment is due in full at the time of appointment. I accept full responsibility for all fees and services rendered. All accounts past 60 days are subject to a $50.00 rebilling fee. If your account becomes past due, we will refer to a collection agency to collect the debt. Returned checks will be charge a $30.00 fee.

Initial here: _____

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 use the disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Initial here: _____

Acknowledgment of receipt of Notice of Privacy Practice and Patients Rights

I, __________________________, have received a copy of this office's Notice of Privacy Practices and Patients Rights. Initial here: _____

Delegation of Power by Parent or Guardian

I give my consent to allow person(s) named below other than myself to accompany and oversee my child for appointments, to release healthcare information for the appointment or to secure payment for dental services. I understand I can revoke this consent at any time providing written notice.

Persons who have consent in my absence are:

1: __________________________ Relationship: __________________________

2: __________________________ Relationship: __________________________

(Only if Applicable)

Signature of Parent/Legal Guardian Date: __________