

SCHEDULING

We schedule your child's appointment according to their individual needs. Because our office strives to run on schedule and time is valuable, we request you give our office at least 48-hour notice if you are unable to keep your child's scheduled appointment. We realize that your time is also valuable, and we do everything possible to keep on schedule; please do your part by arriving on time.

If an appointment is missed or canceled within the 24-hour window, we will review our broken appointment policy with you and we reserve the right to charge your account a \$60.00 Broken Appointment Fee.

FINANCIAL ARRANGEMENTS

Payment is expected at the time of service. For your convenience, we accept cash, CareCredit and all major credit cards. In the case of dental insurance, we will file the dental claim on your behalf for all visits. In order to do this, we need all of the information required by the insurance company plus your insurance company's address to send the claim form. The patient's parent/legal representative is responsible for any unpaid balance, that balance is due upon receipt of our statement. A finance charge of up to 10% of the unpaid balance is automatically added to your account if your balance is not received within 30 days of the statement sent.

By signing this document, I acknowledge that I have read and understand the policies and procedures stated above.

Patient (or Legal Guardian's) Signature

Patient's Name

AUTHORIZATION FOR THE TAKING AND PUBLICATION OF PHOTOGRAPHS

In connection with dental services which, _____, (patient's name) is receiving from my dentist, I authorize that Dr. Staves may display the photograph of the above-named patient(s):

YES _____ NO _____ Inside the office. (Ex: Cavity Free Board)

YES _____ NO _____ On Dr. Staves website or Facebook page. (We do not use any names or identifying information).

I understand that I may revoke this authorization at any time by sending a written notice to the practice.

I understand that I may refuse to sign this authorization.

I fully understand and accept the terms of this authorization.

Patient (or Legal Guardian's) Signature

Patient's Name

Relationship to Patient

Date

PATIENT CONSENT FORM – HIPAA Practices

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. 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 health care 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 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 Policies.
- ❖ The patient has the right to restrict the uses 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 the execution of this Consent.

Patient (or Legal Guardian's) Signature

Patient's Name

Relationship to Patient

Date