GENERAL CONSENT FOR TREATMENT

• SOUTHERN ILLINOIS • Pediatric Dentistry

State law requires us to obtain your consent for your child's contemplated dental treatment or oral surgery. Please read this form carefully and feel free to ask any questions that you may have. We will be happy to explain anything that you do not understand.

I hereby authorize and direct Dr. Christine Wohlford, assisted by other dentists and/or dental auxiliaries of her choice, to perform upon my child (or legal ward) the following dental treatment(s) or oral surgery procedure(s), including the use of any necessary or advisable local anesthetics and/or diagnostic aids (including radiographs, or "x-rays"). You have a right to refuse consent to a procedure before it is performed. In general terms, the dental procedure(s) may include one or a combination of the following:

- Cleaning of the teeth and the application of topical fluoride
- Dental radiographs and/or intraoral photographs
- Application of sealants for posterior teeth that are deemed susceptible to decay
- Treatment of infected or injured oral hard and/or soft tissues including the placement of any restorative materials and/or medicaments deemed necessary, including but not limited to: resin (tooth-colored) restorations, amalgam (silver) restorations, stainless steel crowns, esthetic crowns, temporary restorative materials, and pulpotomies (pulpal therapy)
- Extraction (removal) of one or more teeth
- Replacement of missing teeth with dental prosthesis
- Space maintenance and/or appliance therapy
- Use of nitrous oxide
- Use of a physical restraint device (papoose board) in order to safely and adequately complete the necessary dental procedure- typically only in the case of emergency dental treatment

This treatment has been explained to me and I have had the opportunity to have ask any questions that I have. Alternative methods of treatment, if any, will also be explained to me along with the advantages and disadvantages of both. I am advised that although excellent results are to be expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure.

I hereby state that I have read and understand this consent, and that all questions about the procedure(s) have been adequately answered to my satisfaction. I understand that I have the right to be provided with answers to questions that may arise during the course of treatment. I further understand that this consent will remain in effect until such time that I choose to revoke it.

Patient's name		D.O.B.
Signature of parent/guardian	Relationship to patient	Date
Witness		Date
Signature of Dentist		Date

PATIENT INFORMATION

Patient (Child) Information:

Name: _____ D.O.B.: _____
First M.I. Last

Address: _____
City, State, Zip

Responsible Party (Parent/Legal Guardian) Information:

Name: _____ D.O.B.: _____

Relationship to patient: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Email: _____

Spouse's name: _____

Whom may we thank for referring you: _____

Emergency Contact: _____ Phone: _____

Insurance Information: □ **I have already provided this information (if so please skip)**

Name of Insured: _____ D.O.B.: _____

Relationship to patient: _____ SSN: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Insurance Telephone #: _____

Employer Name: _____

_____

Parent or Legal Guardian's Signature Date

MEDICAL HISTORY

Child's Full Name: _____ Nickname: _____ Date of birth: _____/_____/_____

Gender: □ M □ F Height : _____ Weight: _____ Date of last physical exam: _____/_____/_____

Name/address/phone of primary physician: _____

Name/address/phone of medical specialists: _____

Is your child being treated by a physician at this time? Reason _____ □ YES □ NO

Is your child taking any medications (prescription or over the counter), vitamins, or supplements? □ YES □ NO

List name, dose, frequency & date started: _____

_____

Has your child ever been hospitalized, had surgery, or been treated in the ER? □ YES □ NO

List date & describe: _____

Has your child ever had a problem with an anesthetic? Describe _____ □ YES □ NO

Has your child ever had a reaction or allergy to an antibiotic or medication? List: _____ □ YES □ NO

Is your child allergic to latex or anything else such as metals, acrylic, etc.? List: _____ □ YES □ NO

Is your child up to date on immunizations against childhood diseases? □ YES □ NO

Please mark YES or NO if your child has or has ever had any of the following conditions:

Abnormal bleeding/Hemophilia	□ YES □ NO	Heart Murmur	□ YES □ NO
Anemia	□ YES □ NO	Hepatitis / Liver Problems	□ YES □ NO
Asthma	□ YES □ NO	Hydrocephaly / Shunt Placement	□ YES □ NO
Autism	□ YES □ NO	Hypertension	□ YES □ NO
Complications at birth	□ YES □ NO	HIV/ AIDS	□ YES □ NO
Cancer	□ YES □ NO	Kidney / Bladder Problems	□ YES □ NO
Congenital Heart Defects	□ YES □ NO	Neurological Disorders	□ YES □ NO
Cystic Fibrosis	□ YES □ NO	Pneumonia	□ YES □ NO
Developmental Disorders	□ YES □ NO	Seizures	□ YES □ NO
Gastroesophageal / Acid Reflex	□ YES □ NO	Sinus Problems	□ YES □ NO

Provide details or list any other conditions not listed above:

_____

_____

Dental History

Has your child ever had a bad experience at the dentist? Explain: _____ □ YES □ NO

Has your child ever had a thumb/finger sucking habit? _____ □ YES □ NO

Has your child ever experienced any tooth pain? _____ □ YES □ NO

Is your child currently experiencing any tooth pain? _____ □ YES □ NO

Has your child ever had any facial/mouth trauma? Explain: _____ □ YES □ NO

Do you help your child brush and floss? □ YES □ NO

Does your child use a mouth rinse? What kind: _____ □ YES □ NO

Does your child brush? How often: _____ □ YES □ NO

Does your child floss? How often: _____ □ YES □ NO

Parent or Legal Guardian's Signature Date

Southern Illinois Pediatric Dentistry Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Southern Illinois Pediatric Dentistry ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Southern Illinois Pediatric Dentistry's Privacy Official at:

Bonita Umfleet

1320 Columbia Centre

Columbia, IL 62236

Phone: (618)719-2400

Fax: (618)719-2408

sipdcolumbia@gmail.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on February 4, 2016.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, “business associates”) that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a

written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is February 4, 2016

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE

OF PRIVACY PRACTICES

I, _____, acknowledge that I have been informed of and received a copy of this dental practice's Notice of Privacy Practices.

You may refuse to sign this acknowledgment

_____

Patient name (please print)

_____

Parent/Guardian signature Date

_____

Relationship to patient

OFFICE USE ONLY BELOW THIS LINE

We were unable to obtain written acknowledgment of receipt of our Notice of Privacy Practices because:

_____ Parent or guardian was unwilling to sign

_____ A communication barrier prevented us from obtaining acknowledgment

_____ An emergency prevented us from obtaining acknowledgment

_____ Other: _____

_____

Staff Signature **Date**

PAYMENT AND NO SHOW POLICY

Payment Policy:

The parent or guardian who brings the child to their visit is responsible for payment.

Payment is due at time of service. This includes any co-pays or deductibles or any fee that may not be covered by insurance.

We accept Visa, Master Card, American Express, Discover, personal checks, debit cards, and cash.

- There will be a $25 charge for any returned checks

We also accept Care Credit as a way to help finance your child's dental needs.

We are in network with many insurance providers. We will always do our best to give you the most accurate estimate before each appointment so that there are no surprises. In order to facilitate this, we request that **ALL** information is submitted to the insurance company and provided to SIPD prior to your appointment. In such cases when accurate documentation is not provided, you will be responsible for all charges.

If you happen to be out of network, most likely there are still benefits to you. For your convenience, our business staff will file the insurance claim for you.

Cancellation/No-Show Policy:

There will be a $25 charge per checkup and a $100 charge per treatment appointment if you miss your scheduled appointment time and fail to give at least 24 hours' notice.

We kindly request 2 working-days' notice to cancel or change appointment times. We understand that unforeseen circumstances can arise.

Late afternoon and Saturday appointments are highly requested, if you miss (or late cancel) one of these appointment times you may not be allowed to schedule late afternoon or on Saturdays in the future.

We would be happy to answer any questions that you may have regarding our payment/No-Show policy. Any questions should be directed to our Financial Coordinator, Natalie Hampton.

I have read and understand the Payment Policy of Southern Illinois Pediatric Dentistry and any questions that I have had have been answered to my satisfaction.

Print Name

Parent or Legal Guardian's Signature Date

HIPAA Release of Information

1.) **Patient Name**:_____

First Name / Middle Name / Last Name

2.) **Patient Date of Birth**: _____

3.) **Below I have listed person/s I approve Southern Illinois Pediatric Dentistry to release by child/s dental information to:**

A.)_____ Phone Number: _____

B.) _____ Phone Number: _____

C.) _____ Phone Number: _____

D.) _____ Phone Number: _____

The information that is allowed to be disclosed to this person/s: (Please check-mark each that applies)

_____ Account information (Financial status/outstanding balance)

_____ Outstanding or Current treatment

_____ Upcoming appointment dates/times

Authorization and Signature: I authorize the release of my child/s confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of Parent/Legal Guardian: _____

Printed name Parent/Legal Guardian: _____

• SOUTHERN ILLINOIS •
Pediatric Dentistry

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as “Coronavirus”, at any time or in any place. Be assured that we have always followed the CDC and ADA guidelines in regards to the use of personal protective equipment and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might at your gym, grocery store or favorite restaurant. “Social Distancing” nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patients, dentist, dental staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes _____ No _____

X _____ Date:_____

Parent/Guardian signature