



Welcome back! Dr. Lesley and the South Tampa Pediatric Dentistry team are excited to see you again.

MEDICAL HISTORY UPDATE

Patient: _____ Today's Date: _____

Please list any changes in this child's medical history, including any new medications, since his/her last exam:

Please list any concerns you would like us to pay close attention to at today's visit: _____

CONSENT FOR DENTAL TREATMENT

I, the undersigned parent/legal guardian, hereby give consent for Dr. Lesley and/or clinical staff to examine this child, clean his/her teeth, perform all necessary dental treatment, administer local anesthetics, administer medications, apply topical fluoride, take diagnostic radiographs (X-rays), take clinical photographs, obtain study models and other records necessary for an accurate diagnosis for my child. I understand that dental treatment for children involves behavior guidance, which may include the use of praise, explanation and demonstration of procedures and instruments, variable voice tone, mouth props, nitrous oxide (laughing gas), or protective stabilization when necessary to promote cooperative behavior and a positive experience and to protect my child from potential injury.

Signature: _____ Name: _____

Date: _____ Relationship to Patient: _____

FINANCIAL POLICIES

Payment is expected at the time of service. For your convenience, we gladly accept cash, checks, Visa, MasterCard, American Express, and Discover. We will also file your insurance paperwork for you and accept assignment of benefits from your insurance company. Please note that your out of network insurance reimbursement rates may differ from the fees at South Tampa Pediatric Dentistry. In cases where the fees of South Tampa Pediatric Dentistry exceed those of your insurance reimbursement, you will be responsible for paying the difference.

I agree that I am responsible for all charges for this child's dental treatment. I authorize South Tampa Pediatric Dentistry to file my dental insurance reimbursement paperwork and to call me regarding this account.

Signature: _____ Name: _____

Date: _____ Relationship to Patient: _____

APPOINTMENT POLICY

We reserve your appointment time specifically for you. If you need to reschedule, please give us at least 24 hours notice so that we may give someone else the opportunity to use that time. A fee may be charged for late cancellations and/or missed appointments.

NOTICE OF PRIVACY PRACTICES: HIPAA UPDATE

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her via telephone, mail, or email. You may give us written authorization to disclose health information to anyone for any purpose. This authorization may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency, we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence, we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders/confirmations or treatment recommendations (such as voicemails, postcards, emails, or letters).

Appointment Reminders

We may email you or leave a message with a person or on an answering machine/voicemail to reconfirm appointments. These emails/messages will be of a non-sensitive nature and will include the doctor's name and/or the practice name. You may inform us in writing if you prefer to not have emails/messages of this nature left for you.

Please send appointment reminders and other information regarding this child's appointments to the following email address: _____

Patient Rights

Access: You have the right to look at or obtain copies of your child's health information. If you request copies, we will charge you for each page, for staff time to locate and copy the information, and postage if you request that the copies be mailed.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.

Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means.

Amendment: You have the right to request that we amend your child's health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your child's privacy rights or disagree with a decision we made about access to your child's health information or in response to a written request to amend or restrict the disclosure of health information, you may submit a written complaint to the U.S. Department of Health and Human Services. If you have any further questions about our privacy practices, please ask a staff member.

Signature: _____ **Name:** _____

Date: _____ **Relationship to Patient:** _____

Have there been any changes in your insurance plan? **Yes** **No**

If you have recently moved or changed your phone number, please update the contact information we have on file for you:
