GENERAL DENTAL TREATMENT CONSENT FORM & CONSENT FOR MEDIA PHOTOGRAPHS

CONSENT FOR GENERAL PROCEDURES FOR FIRST AND ALL FUTURE VISITS

1. *Prophylaxis (Cleaning) and Topical Fluoride Treatment*
2. *Dental Radiographs*
3. *Dental Fillings*
4. *Sealants*

ACKNOWLEDGEMENT AND CONSENT

1. I understand that my child may need to receive one or more of the dental services listed above at American Pediatric Dental Group. I am advised that good results are expected; however, the possibility of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment.

2. I fully understand and authorize the dentist to perform any necessary treatment that in his/her judgment will be in the best interest of my child's health, once treatment has begun. Although the occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgical procedures, medication, and/or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, and scarring. I understand and accept that complications may require medical assistance and hospitalization. I also understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the gums or teeth that were not discovered during examination. The most common being the need for nerve (pulp) therapy or extraction following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as he/she deems necessary.

3. I UNDERSTAND THAT PHOTOGRAPHS AND LIVE VIDEO RECORDING ARE USED TO DOCUMENT AND ASSIST WITH MY CHILD'S CARE. These images may be used for insurance claim submittal as well as for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines), including but not limited to, instructional meetings amongst APDG providers and dental assistants. If the photographs or any digital recordings are used in any publication or as a part of a demonstration, my child's name or other identifying information will be kept confidential.

4. **PARENTS/LEGAL GUARDIANS - I UNDERSTAND AND AGREE TO THE FOLLOWING:**
   - A parent (or legal guardian) must be present for each visit and during the entire visit.
   - Legal guardians must bring in appropriate documentation to verify guardianship.
   - If you want to send your child with another adult over 18 years of age, you must fill out a Treatment Decision Assignment form. The designated adult must provide appropriate identification at the time of the visit.
   - Please keep your contact information current with us.

5. **LATENESS - I UNDERSTAND AND AGREE TO THE FOLLOWING:**
   - We enforce a strict lateness policy but we will work with you to keep your appointment provided you call us.
   - Late arrivals will result in longer wait times to accommodate you into the schedule.
   - We reserve the right to reschedule late patients if necessary (a no show will result in a strike on your account).
   - Excessive lateness may result in patient dismissal as well.

6. **LAST MINUTE CANCELLATIONS/STRIKES/PATIENT DISMISSAL- I UNDERSTAND AND AGREE TO THE FOLLOWING:**
   - Please give us at least 24 hours' notice when cancelling or rescheduling your appointment. We enforce a strict cancellation/fail policy. Each cancellation with less than 24 hours' notice or a no show will receive an account strike.
   - Lateness of two or more consecutive times will result in a strike.
   - After two strikes your child will be dismissed as a patient from our office.
   - Due to high demand for Saturday appointments, any last-minute cancellation or no show will result in not being able to have another Saturday appointment for three months.
   - When leaving a voicemail if the time/date stamp on your message is 24 hours or more before your appointment you will not receive a strike.

7. **OTHER OFFICE POLICIES- I UNDERSTAND AND AGREE TO THE FOLLOWING:**
   - Our office considers respect for its team members and patients of paramount importance. Individuals who intentionally act in a disrespectful manner will be immediately dismissed from our office.
   - We take the time to treat children who are apprehensive which may cause appointments to run late at times, but we always strive to see all patients at their appointed time.
   - No eating or drinking is permitted inside our practice.
   - The waiting area has limited seating and we kindly ask that you limit the number of individuals accompanying the patient, whenever possible.
   - Any patient with an after-hours emergency may go to the nearest emergency room such as Joe DiMaggio Children's Hospital located at 1005 Joe DiMaggio Drive, Hollywood, FL 33021.

I acknowledge that I have received and reviewed the American Pediatric Dental Group *General Dental Treatment Consent Form and Clinic Policies and Procedures*. Furthermore, everything herein has been explained to me and I have been given the opportunity to ask questions regarding this consent and any proposed treatment. I also understand that this consent will remain in effect until such time that I choose to terminate it and that such termination must be in writing.

Signature of Patient or Parent/Legal guardian/Personal representative
(*if patient is under the age of 18 or otherwise incapable of signing*)

_____
Please print name below and state relationship to patient.
Name of Representative: _____
Relationship: _____
Date: _____/_____/_____

Consent for Media Photographs

I give my consent for American Pediatric Dental Group ("APDG") to take, or have an outside photographer take, and use photographs of me for publicity ( ), educational ( ), marketing ( ), advertising ( ), and fundraising purposes through internal publication ( ), external publication ( ), radio ( ), television ( ), video ( ), or internet ( ), including social media ( ). [***I have selected any purposes or media format I do not wish included.***]

Such photographs and films will disclose the fact that I have been a patient of APDG and may contain other information about me, including facts that can be inferred from the photograph.

My name may ( ) / may not ( ) be used. [***Select one.***]

I understand the following:

- I am not required to sign this form in order to receive treatment or payment for my care.
- Information used or disclosed under this authorization may be reused by the recipient and may no longer be protected by privacy regulations.
- I may revoke this authorization at any time by notifying APDG in writing, and the revocation will be effective on the date notified (except to the extent action has already been taken based on my earlier consent).
- This authorization will expire in 10 years, unless I have given written notification stating otherwise.
- I will not receive direct or indirect payment for the communication related to the photograph(s).

Name of Patient (s): _____
Street Address/City, State, Zip: _____
Telephone: _____

Signature of Patient or Parent/Legal guardian/Personal representative
(*if patient is under the age of 18 or otherwise incapable of signing*)

_____
If personal representative or parent, please print name and state relationship to patient
Name of Representative: _____
Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

VERY IMPORTANT: THE APDG HIPPA NOTICE OF PRIVACY PRACTICES IS AVAILABLE TO REVIEW AT YOUR REQUEST IN OUR OFFICE AND ON OUR WEBSITE. PLEASE LET US KNOW IF YOU WOULD LIKE A COPY.

I have legal authority for this child and acknowledge that I have access to and am able to review, or have reviewed, a copy of American Pediatric Dental Group's HIPAA Notice of Privacy Practices.

_____	_____	_____
Print Name of Parent or Legal Guardian (**if you are the parent, print, sign and date here only**)	Parent/Legal Guardian's Signature	Date

If you are the personal representative, please state your relationship to the patient that gives you authority over him/her:

❍ Power of Attorney ❍ Other: _____

_____	_____	_____
OR Print Name of Personal Representative	Personal Representative 's Signature	Date

Please Note: It is your right to refuse to sign this acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

❍ An emergency prevented us from obtaining acknowledgement.

❍ A communication barrier prevented us from obtaining acknowledgement.

❍ The individual was unwilling to sign.

❍ Other: _____

_____	_____	_____
Print Name of Staff Member	Staff Member's Signature	Date