



The Little Smile Loft

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Patient Consent Form

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

1. Treatment to be Provided

I understand that during my course of treatment, the following care may be provided:

Examinations, Preventive Services, Diagnosis, Basic Restorative and Crowns.

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. Changes in Treatment Plan

I understand that during 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, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Please read and initial the items below and sign at the bottom of the form.

I have read and understood the above.

X _____

Date: _____

I authorize Dr. Tiffany Jacobs and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally, drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment, items including, but not limited to, crowns, small dental instruments, drill components, etc., may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require

a series of x-rays to be taken by a physician or hospital and may, in rare cases, require a bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past.

I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me, if necessary, and I have been given the opportunity to ask questions.

I have read and understand the above

X _____

Date: _____

NOTICE OF PRIVATE PRACTICES

The Little Smile Loft is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOU AND YOUR CHILD'S PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Healthcare Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your child's treatment, payment, and our dental care operations. Your child's personal health information will never be otherwise given to anyone –even other family members – without your consent. You, of course, may give written authorization for The Little Smile Loft to disclose your child's information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your child's records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your child's protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include you or your child's name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, you and your child's personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use you or your child's information for marketing purposes without your written consent. We may use and/or disclose your child's health information to communicate reminders about your child's appointments including voicemail messages, answering machines, electronic mail, and postcards.

PATIENTS RIGHTS

You have a right to request copies of your child's healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed you or your child's protected information for uses other than stated above. All such requests must be in writing. We may charge you for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services. We thank you for being a part of The Little Smile Loft. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received a copy of the Statement of Privacy Practices (HIPAA Compliance) for The Little Smile Loft. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my child's treatment, payment for services or in the performance of the office's health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to mine and my child's protected health information.

The Statement of Privacy Practices is also posted in the facility. The Little Smile Loft reserves the right to change the privacy practices that are described in the Statement of Privacy Practice. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be emailed to me. This consent will remain in effect until terminated by me in writing.

The undersigned have read and understood the Notice of Privacy.

X _____ Date: _____

INSURANCE & FINANCIAL POLICY

The Little Smile Loft accepts most dental insurance plans. For your convenience, we send a dental claim to your insurance plan electronically the day your child receives treatment. Your insurance company is obligated to pay the claim within 60 days from the date of submission. At that point, we consider the outstanding charges billable to you, the consumer. You will be sent a statement showing the unpaid claims and/or your financial responsibility after all claims have been processed by your insurance provider.

I understand that I am responsible for any charges that are reasonably denied by my insurance company.

I have read and I understand the above.

X _____ Date: _____

PAYMENTS: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

If Insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

If Insurance benefits do not apply, FULL PAYMENT is due at the time of service.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

I have read and I understand the above.

X _____ Date: _____

MISSED APPOINTMENTS:

We value our patients' time, and reserve appointments exclusively for each individual. If you need to make changes to your appointment, we ask that you notify us 48 business hours prior to your appointment to allow us to give your reserved time to another patient. If you do not notify us 48 business hours prior or do not show up for your appointment, you may be

charged our minimum exam fee (\$50 per half-hour). Repeated cancellations or missed appointments will result in loss of future appointment privileges.

In most cases, we will follow the below outlined policy:

1. First Missed Appointment: You will receive an email that goes over our policies. This will be a courtesy warning.
2. Second Missed Appointment: You will be assessed a \$50 missed appointment charge per half-hour and/or limited to schedule same day only appointments. A warning will also be given that if this happens a third time you will be referred out of our office.
3. Third Missed Appointment: Your family will be referred out of The Little Smile Loft.

As a courtesy, we send an email and also call to remind you of your visit. Email and text reminders will provide you the ability to confirm right then and there. If confirmation has not been made, we may remove your child's reserved time if it has not been confirmed within 24 hours of your visit.

It is the Parent/Guardian responsibility to make sure that we have the correct email and phone numbers on file in order to provide this courtesy.

We understand that unforeseen emergencies can happen, we ask you to please inform us as soon as possible so that we can give your reserved time to another child in need of dental care.

I have read and I understand the above

X _____ Date: _____

LATE POLICY

We do our best to accommodate our patient families and to be on time for all of our appointments. When patients arrive late, it can affect our schedule and impact other families. If you are 15 minutes late to your child's appointment, you may be offered our next available appointment or asked to reschedule a non-urgent visit, in order to give your child the best care. Ultimately, it is your responsibility to remember and arrive on time for each appointment scheduled.

I have read and I understand the above.

X _____ Date: _____

I consent to the above policies.

X _____ Date: _____