Privacy Practice (HIPAA) Consent

Acknowledgement of Notice of Privacy Practice

I have read a copy of the Statement of Privacy Practices (HIPAA Compliance) for KSPD. 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.

Kinder Smiles Pediatric Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practice 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 e emailed to me. This consent will remain in effect until terminated by me in writing.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my child's protected health information to the persons indicated below. Please note: in situations where two biological parents are no longer together, information can only be kept private from a bio-parent if ordered by a judge. We must have legal documentation on file if information is to be withheld.

_____

Name of Authorized Persons

Authorization & Consent Statements

*please initial beside each statement after reading

_____I do hereby authorize the doctor and her staff at Kinder Smiles Pediatric Dentistry to provide my child with diagnostic and therapeutic procedures, including dental x-rays and photographs, that may be necessary for proper dental care.

_____I do hereby understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment by using praise, explanation, and demonstration of procedures and instruments using variable voice tones. I authorize this Dental Office to administer such medication, including the use of nitrous oxide ("laughing gas"), which is a mild sedative that is inhaled to reduce anxiety and/or the use of a mouth prop.

_____I do hereby authorize payment directly to this dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and that any estimate given to me is not guaranteed. I authorize the release of any information relative to all claims. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to lima exemption under the constitution and laws of the State of Colorado or any other state.

_____I acknowledge that I have read the Statement of Privacy Practices in accordance with the Health INsurance Portability Accountability Act of 1996 (HIPAA), and am free to obtain a copy of it.

_____

Parent/Guardian Signature Date

Please email completed forms to colin@kindersmilesco.com