Dental Care for Kids
Martha "Jodi" Braid, DMD – Pediatric Dentist
2801-7 Civic Circle Blvd. – Marion, IL 62959 – (618) 998-9868

Attendance Policy

We at Dental Care for Kids have a strong commitment to providing quality dental care to our patients. If you must cancel or reschedule your appointment, you must give us at least 24 hours notice prior to your appointment time. Patients who do not give at least 24 hours notice are considered a no-show. If you miss 3 appointments without proper notification, you will be dismissed from our practice. Please remember that each of your child's appointments count as 1 appointment. **School holidays, as well as before and after school hours are our most popular appointment times. Appointments cancelled with less than 24 hours notice that are scheduled on a school holiday, before or after school time will not be rescheduled on another school holiday, before or after school appointment time.** We know that your time is very important and recognize that abiding by these guidelines allows for better service and availability of appointments for all our patients.

Patient Name	Signature of Parent/Guardian	Date

Dental Care for Kids
Martha "Jodi" Braid, DMD - Pediatric Dentist
2801-7 Civic Circle Blvd. | Marion, IL 62959 | (618) 998-9868

Attendance Policy

We at Dental Care for Kids have a strong commitment to providing quality dental care to our patients. If you must cancel or reschedule your appointment, you must give us at least 24 hours notice prior to your appointment time. Patients who do not give at least a 24 hours notice are considered a no-show. If you miss 3 appointments without proper notification, you will be dismissed from our practice. Please remember that each of your child's appointments count as 1 appointment.
School holidays, as well as before and after school hours are our most popular appointment times. Appointments canceled with less than 24 hours notice that are scheduled on a school holiday, before or after school time will not be rescheduled on another school holiday, before or after school appointment time.
We know that your time is very important and recognize that abiding by these guidelines allows for better service and availability of appointments for all of our patients.

Patient Name _____ Signature of Parent/Guardian _____ Date _____

Authorization for Dental Care on a Minor

I authorize dental treatment to be rendered on my child/minor. _____, without my physical presence in the dental office. I understand that if changes in treatment, complications or medical situations arise, Dental Care for Kids will attempt to contact me. However, I understand that in the event that they are unable to reach me, they will consult with whoever has accompanied my child to determine the treatment that is best to insure the health and comfort of my child until I can be reached. This may result in limited or no treatment being completed during that visit. In an emergency situation, I authorize the Dental Care for Kids team to take any emergency care/action or precaution deemed necessary. I am the custodial parent or legal guardian of _____ and I authorize the following people to bring my child to his/her dental visits and make any decisions for them in my absence*:

_____ _____
_____ _____
_____ _____

I still retain the authority to approve or decline treatment to be rendered and will make that designation clear before the appointment either in person or by phone consent.

Patient Name _____ Signature of Parent/Guardian _____ Date _____

* It is recommended that you put the name of any step-parents, grandparents, or other people that you may ask to bring your child to their appointments. If you do not accompany your child to their visit and the adult accompanying them is not listed here treatment will not be provided. This form will be considered relevant until notified in writing or a new form is completed and given to Dental Care for Kids.

Acknowledgement of Practicing Provider

We at Dental Care for Kids could not be more pleased to have Dr. Amy Wyatt working with us. Dr. Wyatt is a general dentist and have no certification in the specialty of pediatric dentistry.

Signature of Parent/Guardian _____ Date _____

Photographs/Videotaping

We at Dental Care for Kids respect your privacy and will always ask before taking photos of your child or children. We appreciate your same respect for us and expect that you will **always ask for our permission before including us in your photos.** We also ask that you take **no videos during any of your child's visits.** We want to put all of our focus on making your child the star of their visit, but we find it difficult to maintain that focus when being on video. Thank you for your cooperation!

Signature of Parent/Guardian _____ Date _____

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

---

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer _____