PEDIATRIC INFORMED CONSENT & HIPAA

HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
-Obtain payment from third-party payers; and/or
-Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy of Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used and/or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

INFORMED CONSENT (Pediatric Dental Treatment)

I understand that both the dentists and dental assistants may treat my child for the following dental procedures that may be necessary to provide dental treatment. I not only understand that I will be given explanation of performed treatments, but understand that the normal procedures for a first time patient may include a comprehensive or limited exam, dental cleaning, fluoride application, sealants, radiographs (x-rays), fillings, extractions, baby root canals and crowns as necessary. However, this is subject to change depending on numerous factors including patient's behavior, amount of future work needed and time.

In general terms the procedures your child may need include:

Digital X-rays: Taken to help diagnose what procedures need to be done to insure the health of teeth.
Prophy: Removes plaque and food from the teeth, as well as polishes the teeth.
Sealants: Sealants are plastic resin that flow into the grooves on the chewing surface of your molars.
Fillings: Decay exists between your child's teeth and it is crucial that they make sure they know how to brush and floss or decay exists on the chewing surface due to inadequate brushing.
Pulpotomy: The decay, which is caused by bacteria, has reached the living tissue inside your child's primary tooth. This infected tissue needs to be removed.
Root Canal: The decay, which is caused by bacteria, has reached the living tissue inside your child's permanent tooth. This infected tissue needs to be removed. I realize there is no guarantee that the root canal treatment will save my child's tooth and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment, and that this treatment often requires multiple visits and that serious damage or loss of the tooth/teeth involved can be caused if the prescribed treatment is not completed.
Stainless Steel Crown: So much tooth structure has to be removed due to decay that the tooth needs to be strengthened with a stainless steel crown so the patient can continue to chew with that tooth.
Extraction: The primary or permanent tooth cannot be restored due to extensive decay or severe abscess. Extraction is also recommended when a primary tooth will not fall out on its own because there is a root that has not been resorbed by the body. Alternatives to extraction have been explained to me (root canal therapy, pulpotomy, etc..) and I authorize the dentist to remove the necessary teeth as stated in the treatment plan.
Space Maintainer: Maintains the space when a baby tooth is lost early and the adult tooth is not ready to come in yet. Without the space maintainer, the space may close due to the pressure from the adult first molar.
Drugs and Medications: I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting, and/or anaphylactic shock (severe allergic reaction). I realize the risk involved in receiving local anesthetics, some of which are: partial facial paralysis, inflamed tissue, adverse reaction to drugs causing cardiac arrest, hemorrhage, nerve damage/numbness.
Changes in Treatment Plan: I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary.
I hereby request and authorize the Dentists, and their staff, to perform dental work upon my child for the purpose of attempting to improve my child's appearance, functions and the health of their mouth, teeth, bone and tissue, as explained above. The effect and nature of the proceeding to be preformed, and the risk involved, as well as possible alternative methods of treatment have been fully explained to me. I also authorize the operating Dentist and Assistant to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation. I know that the practice of dentistry and surgery is not an exact science and that therefore, reputable practitioners can not properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein requested and authorized. Both my child's treatment and suggested alternative methods of treatment, as well as the advantages and disadvantages of each have been fully explained to me. Complications, such as infection, hemorrhage, and/or bleeding, scarring, contraction, possible deformity, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness and itching of the tongue, lip, teeth, tissue (Parasthesia), fractured jaw, etc., have been clearly explained to me. I understand and accept that certain complications may be fatal or require medical intervention.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature: Date:
Patient or Legal Representative

Legal Guardian Name: Patient Name: