A.

PRIVATE HEALTH INFORMATION AUTHORIZATION FORM

Happy Smiles Kids Dentistry
Main Office: 3737 Moraga Avenue #B109, San Diego, CA 92117
Tel (858) 270-2343 | Fax (949) 627-2495

I authorize my provider to disclose the following private information to the entity identified and for the purpose listed below.

Description of the specific information to be used or disclosed:
Consent to discuss dental treatment and diagnosis, dental appointments, financial information, mailing correspondence and any other dental information not listed would be used to assist the patient's dental needs.

List recipient(s) of the information:____

Person requesting the information and authorized to make the requested use or disclosure:

Name______________________________________ Relationship to patient: ☐ Father ☐ Mother ☐ Guardian

This information is being requested for the following purpose(s): Please see above for prior authorized dental information.

This authorization remains in effect from the date signed below until notified otherwise or ______________________
(Date)

I understand that:

- I may inspect and/or copy the private health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above (Attn: Privacy Officer)
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to prove that research-related treatment)

☐ If this box is checked, I understand that my provider will receive compensation from a third party for the use or disclosure of my information.

Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

B.

ACKNOWLEDGMENT FORM

HAPPY SMILES KIDS DENTISTRY

THIS FORM IS USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

______________________________ ______________________________

NAME OF PATIENT (PLEASE PRINT) **SIGNATURE OF PARENT/GUARDIAN**

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

(OVER)

C.

Patient Dental Materials Fact Sheet

I, ________________________________, acknowledge that I have received a copy of the Dental Materials Fact Sheet issued in 2004.

____

Parent/Guardian Signature Date

D.

Broken Appointment Notice

A broken appointment is a loss to everyone. Please inform us one day in advance if you are unable to keep your appointment. There will be a $75 charge for each broken appointment without 24 hours notice.

Thank You.

____

Parent/Guardian Signature Date

E.

Professional Topical Fluoride and/or Fluoride Varnish Application

The use of fluorides for the prevention and control of cavities is documented to be both safe and highly effective. Clinical studies have shown the effectiveness of *professionally* applied topical fluoride. Fluoride rebuilds your child's teeth to be more resistant to getting a cavity and actually reduces the amount of plaque build-up. Dr. Toppi typically applies a fluoride treatment for your child at each check-up appointment to prevent cavities, although this may not coincide with your dental coverage.

I am giving permission for my child to have a fluoride treatment at each check-up appointment, knowing that it may be denied by my dental insurance plan due to a frequency or non-covered benefit limitation. I am aware that I am financially responsible for the fluoride treatment office fee up to a maximum of $69.00, which is due and payable at the time services are rendered.

____

Parent/Guardian Signature Date

(This authorization is to remain in effect until the office is notified otherwise.)

(OVER)