INFORMED CONSENT FOR ROUTINE DENTAL PROCEDURES

As the patient's parent/ legal guardian you have the right to accept or reject dental treatment recommended by the dentists at Tinker Tooth Pediatric Dentistry. Prior to consenting to treatment, you should carefully consider the anticipated benefits, and commonly known risks of the recommended procedure, alternative treatment, and the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risk, and complications with your child's dentist; we want to make sure all your concerns are addressed. By consenting to the treatment, you are acknowledging your willingness to accept risks and complication, no matter how slight the probability of occurrence.

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

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

1. Treatment Provided**:** I understand that during my child's course of treatment the following may be provided, but not limited to: Examinations, preventative services (fluoride, sealants, and space maintainers), restorations (fillings), crowns, extractions, pulp therapy, space maintenance and radiographs (x-rays). I will be consulted prior to each to appointment.

Initial _____

2. Drugs and Medications**:** I understand that antibiotics, analgesia, anesthetic agents and other medications may cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction).

Initial _____

3. Clinical Photos: For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.

Initial _____

4. Changes in treatment plan: I understand that during treatment it may be necessary to change or add procedures because of the conditions found while working on the teeth that were not discovered during examination. The most common changes are root canal therapy and extraction, following routine restorative procedures. I give my permission to my child's dentist to make any/all changes and additions as necessary. I understand that I will be consulted regarding changes whenever possible.

Initial _____

I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

Initial _____

I confirm that I have read and understand this form or it was read to me.

Initial_____

Parent/ Legal Guardian Signature _____ Date: _____

Notice of Privacy Practices Acknowledgements

I understand that under Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my child's protected health information. State and Federal laws require us to maintain the health privacy of your child(ren)'s health information and to inform you about our privacy practices by providing you with this notice.

A copy of the Notice of Privacy Practices for Tinker Tooth Pediatric Dentistry is available to you. Please ask the receptionist when you arrive if you would like a personal copy. This notice describes how Tinker Tooth Pediatric Dentistry may use and disclose your child(ren)'s protected health information, certain restrictions on the use and disclosure of their health care information and rights you may have regarding your child's protected health information.

Purpose of signing this consent: by signing this form, you will consent to our use and disclosure of your child(ren)'s protected health information (PHI) to carry out treatment, payment activities and healthcare options.

We may share your child(ren)'s PHI including electronic protected health information with other health care providers, to conduct, plan and direct your child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly. We may share your child(ren)'s PHI, including electronic PHI to obtain payments from third-party payers. We may use or disclose your child(ren)'s PHI to notify, or assist in the notification of a family member or anyone responsible for your child(ren)'s care, in case of any emergency involving your child(ren)'s care, location, general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgement to disclose only the information directly relevant to your care.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that the office may restrict how your child's private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand the dental office is not required to agree to my requested restrictions; however, if you agree, that you are bound by such restrictions. I understand that I have the right to revoke this consent except to the extent that we have already acted covered under this consent.

If I choose to revoke that consent, I must do so in writing.

I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities, and healthcare operations.

Contact information:
Child's name: _____ Date of Birth: _____
May we contact you at: ○Home ○Work ○Mobile

Please list persons with whom we may discuss your child's health care information:
_____
Please list persons we may release medical information, including picking up prescriptions:
○ Same as above

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_____

Please list persons who we are **NOT** allowed to release any information to:

_____

If necessary, may we contact your child's pediatrician? Yes ◯ No ◯

Parent/Legal Guardian Signature _____ Date: _____

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Authorization for an alternative caretaker (non-legal guardian) to accompany a Minor to Appointments

I, _____ (Parent/legal guardian's name) authorize the following caretakers:

_____
___

To bring my minor child _____ (child's name) _____ (date of birth) to Tinker Tooth Pediatric Dentistry for scheduled appointments for treatment in which a parent and/ or legal guardian to my child has previously consented be performed on my child.

I understand that this authorization for a caretaker to accompany my child to appointments does not permit the caretaker to consent to treatment on behalf of a legal guardian. I understand that only a legal guardian may consent to treatment for my child.

If treatment consent is required at an appointment in which a caretaker is accompanying a minor child that has not been previously diagnosed and accepted by a parent and/or legal guardian authorized as such with this practice, the legal guardian will be contacted prior to proceeding with the treatment plan. If the legal guardian cannot be reached to provide treatment consent, the treatment will not be performed.

I understand that only a parent and/or legal guardian may accompany my minor child to an appointment in which sedatives are scheduled to be administered, regardless of whether the sedation technique was previously consented to by a parent and/or legal guardian authorized as such with this practice. I understand that this authorization will remain in effect until the practice is otherwise notified of the above designated caretaker's change in status.

I understand that it is my responsibility, as the legal guardian, to inform the practice of any change to this authorization.

○ I decline to list alternative caretakers to bring my child to appointments.

Parent/Legal Guardian Signature: _____ Date: _____

Patient Authorization for Social Media Usage

This patient authorization for Social Media Usage (Facebook, Instagram, etc.) is provided to Tinker Tooth Pediatric Dentistry, in Brownsburg, IN, with respect to the following individual being photographed, video recorded, interviewed or otherwise captured on a media device:

Individual's Name: _____

Parent/ Legal guardian's Name (If child is under 18 years of age): _____

I agree to grant, assign and convey to Tinker Tooth Pediatric Dentistry to any still or motion picture or audio recording made from today's photography and/or interview session.

I agree to irrevocably authorize Tinker Tooth Pediatric Dentistry at its discretion, free of charge and without limitation, to photograph, record, publish, or otherwise copy such material and to broadcast, display, reproduce, edit, exhibit, and distribute the material and any derivative works created from or with it, over television, cable, the internet, or any other communications medium now existing or hereafter created.

This authorization explicitly includes the recording and use of my image, name, likeness, voice and/or biographical information for publicizing broadcast, telecast, distribution, publication or exhibition of Tinker Tooth Pediatric Dentistry. You will not have any right to remuneration derived from the use of these images or this interview.

The materials used are my own for which I have full authority to grant the rights set forth in this document. This Patient Authorization for Media Usage supersedes all prior agreements pertaining to its subject matter and cannot be amended without the prior written agreement of an authorized representative of Tinker Tooth Pediatric Dentistry.

- ○ I consent to have my child's photo taken.
- ○ I decline to have my child's photo taken.

Parent/ Legal Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

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