AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

and

AUTHORIZATION OF PERSONS TO CONSENT FOR TREATMENT IN THE ABSENCE OF PARENT/GUARDIAN

This form is to be completed by the PARENT or GUARDIAN of a minor (under age 18) patient, if the PARENT/GUARDIAN wishes to authorize other individuals (such as a grandparent, aunt/uncle or family friend) to accompany the minor patient to appointments and consent to treatment of the minor patient. When the PATIENT reaches age 18 or if the PATIENT has been legally emancipated, the PARENT/GUARDIAN no longer has the right to consent to treatment or to authorize anyone else to do so. **Notwithstanding the foregoing, in the Commonwealth of Pennsylvania, a medical professional may discuss a minor Patient's protected health information with a non-Authorized party if, in their professional judgment, it is vital to the care of the minor Patient and no Authorized party is present.**

(Child /Children)

SECTION A: PATIENT INFORMATION [If more than one patient in same family, please list ALL patients below]:

Name(s): _____

Address: _____

Telephone: _____ Alt. Telephone: _____

(Birth or Biological Parent)

SECTION B: INDIVIDUAL AUTHORIZING ON BEHALF OF PATIENT

Name: _____ Relationship to Patient: _____

[NOTE: If there is a custody agreement, this individual must be the person who has healthcare decision-making rights for each child listed above.]

☐ *Check if address is the same Patient's address listed above*

If Different: Address: _____

Telephone: _____ E-mail: _____

OTHER PARENT/GUARDIAN: *(Court ordered–legal document stating the guardian by name.)*

Name: _____ Relationship to Patient: _____

PLEASE COMPLETE BACK OF THIS PAGE

SECTION C: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

By completing and signing this form, you confirm and **authorize the disclosure of protected health information (PHI) of the minor patient** and/or **authorize the accompaniment for treatment and consent for treatment of the minor patient(s)** listed above to the individuals listed below:

**Anyone birth parent is authorizing to bring patient to appointment.* PHI Disclosure — Accompaniment/ Consent to Treatment
** Friend, Family, Relative, Neighbor, Nanny, Babysitter*

Individual's Name: _____ ☐ _____ Initial Here ☐ _____ Initial Here
Relationship to Patient: _____
Address: _____
Phone No.: _____

Individual's Name: _____ ☐ _____ Initial Here ☐ _____ Initial Here
Relationship to Patient: _____
Address: _____
Phone No.: _____

Individual's Name: _____ ☐ _____ Initial Here ☐ _____ Initial Here
Relationship to Patient: _____
Address: _____
Phone No.: _____

Individual's Name: _____ ☐ _____ Initial Here ☐ _____ Initial Here
Relationship to Patient: _____
Address: _____
Phone No.: _____

Signature of Birth /Biological /Court Ordered Guardian /Individual:

_____ Parent/Guardian Signature

Date: _____

_____ Witness (Center Employee) Signature

_____ Witness Name & Job Title

NOTE: Notary required only if form is completed <u>outside of the Center</u>

Sworn before me this _____ day of _____, _____, in the County of _____, Commonwealth of Pennsylvania.

_____ (seal)
Notary Public

_____ _____ My commission expires: _____
State County

YSDC Patient Information

Patient Name: _____ Date: _____
Last First

Birth Date: _____ Age: _____ ☐ Male ☐ Female How Did You Hear About This Office?: _____

Mother/Legal Guardian _____ DOB _____ **Father / Legal Guardian** _____ DOB _____

Phone (Home): _____ (Cell): _____ Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

DOES THE PATIENT HAVE ANY HEALTH ISSUES AT THIS TIME? ☐ Yes ☐ No

Please check those that apply:

- ☐ ADHD
- ☐ AIDS/HIV
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ Birth Defects
- ☐ Cancer
- ☐ Clotting Disorder
- ☐ Diabetes
- ☐ Disabilities/Special Needs
- ☐ Epilepsy
- ☐ Fainting
- ☐ G6 PD
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Trouble
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Sickle Cell
- ☐ Sickle Cell Trait
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Use of Diet Aids
- ☐ Anesthesia Allergy
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Allergies
- ☐ Speech/Hearing Problems

- If you answered "Yes" to any of the above, please explain:

_____

- Does the patient have any other health problems? ☐ Yes ☐ No
  If yes, please explain: _____
- Has the patient had surgery? ☐ Yes ☐ No
  If yes, please explain: _____
- Is the patient taking any medications at this time? ☐ Yes ☐ No
  If yes, please explain: _____
- Is the patient allergic to any medications? ☐ Yes ☐ No If yes, What? _____
- Does the patient have any dental problems/concerns at this time? ☐ Yes ☐ No
  If yes, please explain: _____
- Nearest Relative: _____ Telephone: _____ Relationship: _____
- Please list Other Siblings Seen Here: _____
- Patient's Pediatrician: _____ Telephone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Consent for Services

As a condition of your treatment by this office financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature: _____ Printed Name: _____ Date: _____ Relationship to Patient: _____

Youth Smiles Dental Center
5918 Penn Avenue
Pittsburgh, PA 15206
412-361-5437 Phone
412-361-2019 Fax

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Youth Smiles Dental Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Youth Smiles Dental Center has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Youth Smiles Dental Center will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Youth Smiles Dental Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Youth Smiles Dental Center has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Youth Smiles Dental Center, 5918 Penn Avenue, Pittsburgh, PA 15206.

FORM Us

Dentistry Patient Management Techniques

Patient(s) Name:_____

It is our intent that all professional care delivered in our center be the best possible quality we can provide for each patient.

Providing high quality care requires that we teach children to become cooperative patients by guiding their behavior. Among the uncooperative behaviors that can interfere with the proper management of quality dental care are: hyperactivity, resistive movements, refusal to open mouth/keep open long enough to perform the necessary dental treatment, and even aggressive and/or physical resistance to treatment, such as kicking, screaming, and grabbing at the dentist's hand or the sharp dental instruments.

All efforts will be made to obtain the cooperation of dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, understanding, and the use of the following techniques:

1. Tell-Show-Do: The Dentist or assistant explains to the patient what is to be done using simple words then shows the patient what is to be done by demonstrating with instruments on a model or the patient's or Dentist's finger. Praise is used to reinforce cooperative behavior.

2. Positive Reinforcement: This technique rewards the patient who displays desirable behavior. Rewards include compliments, praise, and a pat on the back, a hug, or a prize.

3. Voice Control: The attention of a disruptive patient is gained by changing the tone and increasing the volume of the Dentist's voice. The louder voice is controlled, and the Dentist is not angry. Content of the conversation is less important than the abrupt or sudden nature of the command.

4. Reassuring Touch by the Dentist/Dental Staff: The Dentist and/or Dental Assistant hold the child's hands to a safe position. Reasuring touch is not part of protective stabilization described below.

5. Mouth Props: A mouth prop, sometimes referred to as a "tooth pillow", may be used with cooperative patients to help them keep their mouths open during treatment.

If you have any questions about any of the above techniques, please ask. Note: If you do not agree with any of the above methods listed, please let us know so that we may talk to you about them. But realize that it therefore may not be possible to complete any dental treatment for your child in a safe environment.

I, _____, certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I further understand that if stabilization or nitrous oxide will be used techniques will be explained in greater detail and a separate consent form will be obtained for each.

Parent/Guardian:_____ Date:_____

If any of the following techniques are recommended, you will be given further explanation and a seperate consent will be necessary:

1. Protective Stabilization by the Dentist: The dentist stabilizes the patient from movement by holding the patient's hands or upper body, stabilizing the patient's head between the dentist's arm and body, or positioning the patient firmly in the dental chair.

2. (Active) Protective Stabilization by the Assistant or the Parent: The assistant or parent stabilizes the patient from movement by holding the patient's hands, stabilizing the head, and/or controlling leg movements.

3. (Passive) Protective Stabilization - Papoose Boards and Pedi-Wraps: These are stabilizing devices for limiting the disruptive patient's movements to prevent injury to themselves, the dentist, the dental assistant, and others in the treatment area. The patient is wrapped in the device and placed in a reclined dental chair.

4. Nitous Oxide and Oxygen: Also known as laughing gas, nitrous oxide and oxygen may be provided for the patient to breathe through a nasal mask. Nitrous oxide is used to reduce anxiety. The patient does not become unconscious. The effects are completely reversible at the end of the procedure.