CONSENT FOR TREATMENT at Kids Dental, P.C.

We would like to welcome you and your child to our office. It is important that we inform you about the various procedures provided in Pediatric Dentistry. Informed consent is necessary before starting your child's treatment. Please take a moment to carefully read this form. Since, patient is a minor, it is necessary that signed permission be obtained from parent or legal guardian before any dental services can be started and accomplished by Dr. Lisa Lazzara or any other doctors, hygienists, assistants, or staff associated with Kids Dental, P.C.

Authorization is hereby granted to perform examinations, take x-rays and/or photographs, clean teeth, administer fluoride treatments, and provide oral hygiene instruction if deemed necessary.

After thorough examination, if further treatment is necessary, authorization is hereby granted to administer local anesthetics and/or nitrous oxide analgesia and perform any treatment (i.e. x-rays, photographs, cleaning, sealants, white or silver fillings, pulp therapy, composite crowns, stainless steel crowns, extractions, space maintenance, tooth movement) and/or such operations, or treat my child/children as it may be deemed necessary or advisable by Dr. Lisa Lazzara or any other doctors, hygienists, assistants, or staff associated with Kids Dental, P.C. I also give permission to provide my child/children with emergency care if needed. I have had the treatment plan(s) for my child/children explained to me. The risks involved with those procedures, alternatives to those procedures, risks therein involved, and the risks of no treatment at all have also been explained to me, and I understand the explanations. I have been given the opportunity to ask questions and have those questions answered.

Unless otherwise requested below, we will use white/composite fillings. In some cases, the co-pay may be slightly higher for white/composite fillings than the silver/amalgam fillings.

_____ I request **WHITE**/composite fillings for my child/children

_____ I request **SILVER**/amalgam fillings for my child/children

_____ I request **WHITE**/composite fillings for **adult** (permanent) teeth
and **SILVER**/amalgam fillings for **baby** (primary) teeth for my child/children

I hereby acknowledge that I have read and understand this consent form, and this consent shall remain in effect for my child/children until I choose to terminate it and I will give written notification to reverse this document.

Patient Name _____________________________ Relationship to Patient ________________________

Signed Name (Parent/Legal Guardian) ____________________________ Date: ________________

NOTICE OF PRIVACY ACKNOWLEDGEMENT KIDS DENTAL, P.C.

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 whom may be involved in the treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications
- Confirm or verify appointment information when messages may be left on answering machines or cellular telephones

I authorize my child's/children's pediatrician or other physician(s)/medical facilities to release any and all pertinent medical information regarding my child/children, I also authorize the release of pertinent information to those persons requiring it for treatment of my child/children or for the purpose of payment of the account or credit references. I authorize transmission, electronically or other means of data for payment/communication purposes including, but not limited to, insurance companies.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of uses and disclosures of my health information. 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

PATIENT NAME __________________________ Relationship Patient ____________________________________

Signature of Parent/Guardian ___________________________________ Date ______________