Chillicothe Pediatric Dentistry

Office Policies and Releases

Patient's Name: _____ **DOB**: ____/____/____

Standing Policies

1. **Our office (Chillicothe Pediatric Dentistry, or "CPD") requires a 24-hour notice of cancellation for scheduled appointments. Broken appointments are very costly to us, both in lost available schedule time and production. Therefore, if a documented pattern of missed, unexcused appointments is noted, you will be asked to transfer your child to another dental office.**

2. **The doctors and staff at CPD encourage parent involvement and input in the treatment process. Parents are welcome into our treatment areas with their child/children, primarily for cleaning/check-up appointments. We do prefer you to allow us to accompany school-age children (6 y/o and above) through restorative appointments (e.g. fillings, extractions, sedations, or when laughing gas is used) alone, as we are very confident in ushering them through these appointments calmly and without incident. Please feel free to call with any questions or concerns prior to your child's appointment at 740-773-8320.**

3. **For the confidentiality of our staff and patients, we ask that you do not take any photos or record any video in our treatment areas. We will be happy to pose for pictures before or after appointments, and only with the approval of our staff.**

Releases

1. **I hereby authorize CPD to perform preventive, diagnostic, and treatment procedures (e.g. x-rays, anesthesia, nitrous oxide/laughing gas, etc.) as deemed necessary by the treating dentist or his/her designated auxiliary. We will always include you in formulating a plan for care, and get your input and verbal approval at most appointments. Occasionally, changes in our plan become necessary, and will be discussed with you, if/when any changes becomes necessary. If you send someone to an appointment in your stead, they should have written authorization from you to consent for approving changes to our planned treatment.**

2. **I hereby authorize CPD to release any information necessary to insurance carriers regarding my child's dental or health condition, as well as treatment rendered, for the purpose of processing insurance claims, pre-authorizing care, or following up on information requested by your insurance carrier.**

3. **I hereby authorize CPD to request or release information necessary to effectively communicate with referring medical or dental professionals, in an effort to effectively and safely carry out (or provide referral information) for planned care. I have been offered a copy of CPD's HIPAA Notice of Privacy Practices (also available on our website,) and have had any pertinent questions answered.**

5. **I understand that insurance co-payments are due at the time services are rendered. I understand, by signing below, that I am responsible for ensuring that these out of pocket costs are paid, or I will make arrangements to guarantee payment. I have been offered a copy of CPD's Financial Guidelines (also available on our website,) and had any pertinent questions answered.**

6. **I hereby authorize and direct my insurance carrier(s) to issue payment checks directly to Ronald A Griffin, DDS, LLC for services rendered to my child.**

7. **I consent to the use of nitrous oxide ("laughing gas") during dental treatment at CPD. (Further, a Nitrous Oxide Sedation Information Sheet is available upon request.)**

8. **I give permission for my child's image to be used on CPD's website (www.chillicothekidsdentist.com) and/ or Facebook page for fun and/or promotional purposes.**

"I have read and understand the above information and have had all my questions answered."

_____ _____

Parent or Guardian Signature (Patient, if adult) Date