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Discovery Pediatric Dentistry

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Consent for Examination, Treatment, and Assignment of Insurance Benefits

Since your child is a minor, it is necessary that a signed permission form from a Parent or Legal Guardian be obtained before performing diagnostic and treatment procedures. Therefore, the Parent or Legal Guardian has to be present in the office during a regular or emergency diagnostic examination. The diagnostic procedures will include necessary x-rays, cleaning/fluoride, and a thorough examination by the Doctor. I hereby give Discovery Pediatric Dentistry permission for my child to have diagnostic procedures. This consent for diagnostic procedures shall remain in effect until revoked in writing.

I hereby give Discovery Pediatric Dentistry permission to treatment plan the necessary dental care for my child. I understand that this treatment may include additional oral and x-ray diagnosis by the Doctor. I give my permission for the use of local anesthesia, nitrous oxide/oxygen analgesia, and behavior modification techniques for the safety and well being of my child. I understand that I will be personally informed of the diagnosis, Treatment Plan, materials, and procedures used to restore my child's teeth to their optimum condition. I will have the opportunity to ask any questions about the diagnosis and Treatment Plan before I give my final written Informed Consent for Treatment.

I understand that there are some risks in the use of local anesthesia such as prolonged numbness, biting of soft tissue, and allergic reaction. I understand that there are some risks in the use of nitrous oxide/oxygen analgesia such as nausea, dizziness, and disorientation. I further understand that I can at any time request further consultation about any of the procedures used in this office and revoke in writing this Informed Consent for Treatment.

Our Office Policy Regarding Insurance Assignment

We will bill your insurance carrier after every visit as long as your child is receiving care in our office. This courtesy may be withdrawn if circumstances warrant. You will need to sign this "Assignment of Benefits" form and other documents as required by your insurance company. Our office does not guarantee that your insurance will pay. We will make every attempt to get prompt verification of your eligibility and benefits. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill. It must be fully understood that the contract is between you and your insurance company. If your insurance company requests additional information from you in order to process your claim, you agree to respond to your insurance company immediately. We would like you to send to us a copy of their request and your response to include in the chart.

I hereby authorize Discovery Pediatric Dentistry to furnish information to the appropriate insurance carriers concerning all treatment provided and hereby assign all payments for dental services rendered to my child to Discovery Pediatric Dentistry.

I hereby instruct the _____ Insurance Company to make payment by electronic direct deposit or by check made payable to:
Insurance Company Name

Discovery Pediatric Dentistry 1700 California Street Suite 200 San Francisco, CA 94109-4582

for the dental or medical benefits allowable, otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by Discovery Pediatric Dentistry. I understand and agree that I am financially responsible for all charges whether or not paid by the insurance company. In the event of default, I agree to pay legal interest on the indebtedness, together with such collection costs and attorney fees as may be required.

A photocopy of this assignment shall be considered as effective and valid as the original. This assignment shall remain in effect unless revoked in writing by the policyholder.
This Signature on File used for Electronic Claim Transmission will also remain in effect until rescinded by the Insured in writing.

_____ **Date** _____ _____ **Date** _____
Signature of Policyholder **Signature of Claimant, if other than Policyholder**

Authorization to Disclose Information to Insurance Companies, Professional Dental Associations & Societies, and Governmental Departments For Claim Dispute Resolution Process Regarding the Health Insurance Portability and Accountability Act (HIPAA) of 1996

I voluntarily authorize Discovery Pediatric Dentistry to act as enrollee's designated and authorized agent or representative, to contact said insurance companies, associations, and governmental departments on behalf of the enrollee and/or his/her dependent covered by the insurance plans in dispute, and to release, exchange, and receive any information pertinent to any claim in dispute from any insurance company, adjuster, attorney, or professional dental organization such as the American Dental Association, the California Dental Association, the San Francisco Dental Society, or any other professional organization or governmental department involved in this dispute and resolution process to secure payment for services rendered.
Signatory authorizes disclosure via oral, paper, or electronic interchange of all records, claims, and other information regarding the treatment of named patient and all records, claims, other information, or correspondence between insurance companies involved with any claim dispute and resolution process and Discovery Pediatric Dentistry.

I _____, hereby authorize and request Discovery Pediatric Dentistry to release the Medical / Dental records and claim information of**:**
Name of Patient, Parent, or Legal Guardian

_____ **Date of Birth** _____
Patient's Complete Legal Name

The recipient may use the claim information, treatment information, and other related information involving such claims authorized on this form for the following purposes of: *claim dispute and resolution processes*.

The signatory understands that the information will remain confidential to all other parties and hereby releases Discovery Pediatric Dentistry from any and all liability related to disclosure of confidential or privileged information.

DURATION	This authorization shall become effective immediately and shall remain in effect until rescinded in writing by the insured patient, parent, or legal guardian.
REVOCATION	This authorization is subject to written revocation by the patient, parent, or legal guardian at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or o others have previously acted in reliance upon this authorization.
REDISCLOSURE	The signatory understands that the recipients may not lawfully further use or disclose the health information from this claim dispute and resolution process unless another authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

This Signature on File will remain in effect until rescinded in writing by Patient, Parent or Legal Guardian. A photocopy of this document may act as an original.

_____
Name of Patient, Parent or Legal Guardian *authorized to consent for patient* *(Please Print)*

Address _____ ZIP_____

_____ **Date** _____
Signature of Patient, Parent, or Legal Guardian

Patient Name _____

Revised 10/17/13