

**PATIENT CONSENT – MINOR CHILD
(Effective until age 18 - Tennessee)**

Your Child(ren)'s Names:

Patient's Name _____ DOB: ___/___/___
Patient's Name _____ DOB: ___/___/___
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Patient's Name _____ DOB: ___/___/___

Clinical

1. As the parent/legal guardian of the child(ren) listed above, I authorize PROVIDENCE DENTAL CARE to perform all recommended treatment on the patient, including but not limited to:
 - a. Routine dental care, which may include, but not limited to: Dental exams, prophylaxis (cleaning), fluoride treatment, x-rays and any and all other treatment previously discussed and agreed upon by the parents/legal guardian.
 - b. Emergency or urgent care when I cannot be reached

Financial

2. I am responsible for payment for all services rendered for my child. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

Maintaining Appointments

3. I am aware that when appointments are broken or cancelled at the last minute, valuable clinical time is voided, time that could have been spent serving another patient, especially a patient in pain. A \$40 missed appointment fee will be charged to my account for all missed appointments or last-minute cancellations by me. I am aware that to hold down operating costs, 48-hour notice of cancellation is required.

Insurance

4. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

If you authorize sharing protected health information, complete the HIPAA Acknowledgment section below.

HIPAA Acknowledgment

5. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, specialty dentists involved in my child's care, any and all information, records, and other diagnostic material about my child's medical history, services rendered, or recommended treatment.
6. I acknowledge receipt of the Notice of Privacy Practices.
7. I authorize sharing my child's protected health information with the following individuals who may be involved in my child's care and I understand I am responsible to notify the Practice of any changes:
 - a. Name: _____ Relationship: _____
 - b. Name: _____ Relationship: _____
 - c. Name: _____ Relationship: _____
8. I authorize the following means of communication:
Home Number: _____ to include a message
Mobile Number: _____ to include a text message and voice message
Email: _____ Other: _____

Parent/Legal Guardian's Signature: _____ Date: _____ P 1/1