Thank you for choosing NC Pediatric Dentistry to care for your child/children's dental care needs.
The following new patient forms can be printed or emailed to the appropriate office. If emailed, please remember to save before sending.

Please refer to the following list for the appropriate email address to each office:

Anson Pediatric Dentistry- acfpd@ncpediatricdentistry.com
Denver Pediatric Dentistry- dpd@ncpediatricdentistry.com
Locust Pediatric Dentistry- lopd@ncpediatricdentistry.com
Lincolnton Pediatric Dentistry-lpd@ncpediatricdentistry.com
Statesville Pediatric Dentistry- stpd@ncpediatricdentistry.com
Salisbury Pediatric Dentistry- spd@ncpediatricdentistry.com
Cabarrus Pediatric Dentistry- cp@ncpediatricdentistry.com
Caldwell Pediatric Dentistry- ccpd@ncpediatricdentistry.com
Mooresville Pediatric Dentistry- mpd@ncpediatricdentistry.com
Fuquay Pediatric Dentistry – FPD@ncpediatricdentistry.com
Afton Pediatric Dentistry- ADP@ncpediatricdentistry.com

Thank you again, and we look forward to serving you!

Authorization to Release Health Information

Patient Information:

Name of Patient_____Date of Birth _____

Address_____

City, State, Zip_____Phone _____

At my request,_____may release the following information:
(Name of the entity)

☐ Entire record ☐ Financial records ☐ Office visit notes
☐ Marketing* ☐ On site record review by the patient
☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
☐ Diagnostic studies (list):

☐ Other as listed

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name_____

Address_____

City, State, Zip_____Phone _____

☐ **Send the information electronically. Email address: _____**

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

NC Pediatric Dentistry
Authorization for Release of Information – Compound Release

Name of Patient_____Date of Birth _____

NC Pediatric Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment Reminders
☐ Other person (s) (provide name and phone number) (i.e. Nanny, Stepparent, Grandparent, Friend, Relative etc.) ☐ _____ ☐ _____ ☐ _____	☐ Financial ☐ Treatment
☐ Email communication -Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2014

Financial Policy

Thank you for choosing us as your dental healthcare providers. We are committed to providing you with the highest quality care in a compassionate, professional, and timely manner.

Payment in full is required at the time of service for non-insured patients. Payment of the estimated portion and or co-pays (or the balance in full if your carrier will not reimburse us directly) is required for insured patients at the time of service. In-house payment plans are available and we also offer patient financing programs through a third party.

Any estimate given on any treatment needed is subject to change if additional information is revealed through further clinical examination or radiographs. Once a patient is aware of what is taking place and allows treatment, patient is responsible for payment of additional treatment.

Our practice is not a preferred provider for every insurance carrier. We will file any insurance claims as a courtesy to you. Our office will need to disclose your personal information to your insurance for reimbursement. The benefit percentages quoted are based on "UCR" or "usual, customary, reasonable" and are determined by your employer and the insurance carrier.

Your dental insurance plan is an agreement between your employer and its selected insurance company. Dental care is provided to the patient, not to the employer, nor to the insurance company. As a result you are responsible for full services payment to NC Pediatric Dentistry. We will accept assignment of benefits to come to us as your provider. Any balance that results from your carrier's denial or deviation from our estimated benefits payments remains your responsibility. Any account for which an insurance claim has been filed and has not been paid after 90 days may be subject to further action by you or full payment by the responsible party. If at that time you do not respond or the responsible party does not make payment, then your account may result in further collection actions as stated below.

Any account that remains unpaid after 45 days may incur a collection service fee of $25 and may be turned over to a third party for collection purposes. In case of delinquent or default account, Patient/Responsible Party is liable for any and all collection and/or reasonable Attorney fees.

A returned check reimbursement charge of $25.00 or the maximum allowed by North Carolina State law will be issued to any account on which payment has been refused by the payer bank because of insufficient funds or because the drawer did not have an account at that bank.

We require a 24-hour notice when canceling or rescheduling an appointment. Our policy for broken or missed appointments follows: For patients who (1) are chronically late, (2) frequently fail to show or (3) chronically reschedule or cancel on the day of the appointment will be put on a call list or possibly dismissed from the practice.

By signing below the patient accepts the terms of this financial policy.

Patient Name: **Patient or Guardian Signature:**

Date:

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

Patient Name and Address:

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature: Date:

For Office Use Only

We were unable to obtain a written Acknowledgement of Receipt of Notice of Privacy Practices because:

- *An emergency existed and obtaining a signature was not possible at the time*
- *The individual refused to sign.*
- *A copy was mailed with a request for a signature.*
- *We were unable to communicate with the patient for the following reason: _____*

- *Other_____*

Prepared by_____

Signature: *Date:*

Missed Appointment, Confirmation and Late Arrival Policies

Our office maintains a 24-hour cancellation policy in consideration of other children/families needing emergency care due to the occurrence of a dental accident or being in pain. We appreciate your understanding, inevitably there will likely be a time when your child is in need of an emergency appointment or your schedule changes.

Missed Appointment (No-Show) Policy

Effective immediately, we will implement a missed-appointment policy that affects ALL patients that do not maintain their scheduled appointments and/or who cancel an appointment with less than a 24-hour notice.

▪ **First missed appointment** – Parent/Patient will receive electronic notice of failed appointment informing of the following stipulations

- Families will no longer be scheduled together
- Highly desirable appointment times will not be available

This notice must be signed and returned in order to schedule any subsequent visits.

▪ **Second / Final missed appointment** – Patient/parent will receive final letter dismissing patient from the practice for the foreseeable future.

▪ Should you miss a specialty appointment (Laser services, PDAA, GA, Hospital) unexcused, you will no longer be permitted to schedule these services again with our organization.

Confirmation Policy

Appointment confirmation is required by **2pm day prior** via our text confirmation system or personal call. If your appointment has not been confirmed prior to 2pm, your appointment will be removed from our schedule. Your appointment will be placed in our work-in column and your appointment time will not be reserved. You will receive notification via text / call when this change takes place.

Late Arrival Policy

Patients arriving more than 10 minutes late for a scheduled appointment will be rescheduled and considered a missed appointment, subject to the Missed Appointment policy above, regardless of the circumstance.

Patient Name: _____

Parent/Guardian Signature: _____ Date: _____

Parental Treatment Consent

Patient Name and Address:

I,_____parent/legal guardian give the following person(s) permission to accompany my child to dental appointments, allowing them to make financial and treatment decisions on my behalf. I understand that medical history and consent must be updated and signed yearly by a parent or legal guardian. VERBAL CONSENT CANNOT BE ACCEPTED.

Person bringing child must be 18 years or older, must be listed below and will be asked to show a valid ID.

A child under the age of 18 must be accompanied by an adult listed below.

In order to remove someone from this list the parent or legal guardian must come in person with a valid ID and sign a new consent.

Person/Relationship:

Person/Relationship:

Person/Relationship:

Signature: **Date:**