Sprout
PEDIATRIC DENTISTRY

2022 acknowledgement of receipt of notice of privacy practices

initial _____

This form is used to obtain acknowledgement of receipt of the office Privacy Practices or to document good faith effort to obtain that acknowledgment. This form is also to state that the doctors of Sprout Pediatric Dentistry have the authorization to contact any other doctors, if necessary, to discuss plan of treatment for your child. I.e. speech therapist, chiropractor. previous dentist. I understand that the patient's protected health information can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policy at any time.

delegation of power by parent or guardian (if applicable)

initial _____

I give consent to allow person(s) named below other than myself to accompany and oversee my child for appointments, to release healthcare information for the appointment or to secure payment for dental services. understand I can revoke this consent at any time by providing written notice. Persons who have my consent in my absence are:

1.	2.

failed appt/late arrival

initial _____

If you cannot come to a dental appointment, you will need to notify the office to re-schedule. If you cancel the day of your scheduled appointment or fail to show 2 (two) times, we will no longer pre-schedule any future appointments. You may be seen on a space availability basis only. If you come more than 15 minutes late for an appointment, you may or may not be seen that day. There may be emergency patients waiting on "standby" who will be seen in your place if more than 15 minutes late.

appointment confirmation

initial _____

All appointments must be confirmed 24 hours in advance. Families greater than 2 must be confirmed 48 hours in advance. We sent confirmation texts to the number you provided when scheduling. If we do not receive confirmation for your appointment, we reserve the right to double-book your appointment, which could result in having to wait until the child can be seen.

authorization of recommended services

initial _____

Sprout Pediatric Dentistry follows the guidelines set forth by the American Academy of Pediatric Dentistry. Insurance companies may not always cover recommended services. We recommend a topical fluoride varnish to be applied to the teeth every 6 months as a preventative measure to help lower the risk of decay. There may be a charge up to $40 once per year for this preventative service. **If you would not like topical fluoride please notify the assistant working with your child.**

Initial and future visits

initial _____

At your child's initial appointment, we will take radiographs, professionally clean their teeth and apply a prescription fluoride treatment (pending the child's age and ability to tolerate services). At future visits, radiographs will be taken according to the AAPD guidelines. Before your child's visit, please let us know if you object to any of the above services.

Patient's name: _____ Legal guardian signature: _____