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

The parent or legal guardian must complete this form for a minor, provide consent for dental treatment, and accompany the child during each dental visit. Treatment will not be provided for unattended minors unless it is an emergency. If you wish to designate another adult to be a decision-maker in your child's dental care, please complete the Limited Power of Attorney. If you authorize sharing protected health information, complete the HIPAA Acknowledgment section below.

Your Child(ren)'s Names:

Patient's Name_____DOB: ___ /___/___
Patient's Name_____DOB: ___ /___/___
Patient's Name_____DOB: ___ /___/___
Patient's Name_____DOB: ___ /___/___

Clinical

1. As the parent/legal guardian of the child(ren) listed above, I authorize _____ (Name of Practice) to perform all recommended treatment on the patient, including but not limited to:

    a. All recommended treatment;
    b. Radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis;
    c. The use of anesthetics, nitrous oxide, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

2. I am responsible for payment for all services rendered for my child. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. 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 $50 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, 24-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.

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