Jennifer K. Hargleroad, DDS, MS
Professional LLC
Board Certified Pediatric Dentistry

Welcome to our practice and thank you for choosing our office! We look forward to teaching your child the importance of forming healthy dental habits that will last a lifetime.

During your initial visit, we will review your child's medical and dental history and address any concerns you have about your child's teeth. In order to facilitate this process, we encourage you to fill out all of the new patient forms ahead of your appointment day. You can access them on our website ( www.fckidsdentist.com ) by clicking on the following link: www.fckidsdentist.com/patient-portal

You may print the forms, then scan and email them back to us at doctor@fckidsdentist.com or if you save the blank PDF document to your computer BEFORE you fill out the information, you can attach the PDF document and send it to our email to avoid having to print anything out. If you'd rather receive our new patient information packet by mail, simply call and ask one of our front office team members to do so.

Our goal is to maintain our fees as low as possible. If you would like our office to assist you with insurance processing, please contact our office with the appropriate dental insurance information prior to the scheduled appointment. Please also bring the appropriate dental insurance card to this first visit so that the information can be scanned into our system. We request payment on the day services are rendered. Any anticipated dental insurance plan benefits will be applied to this fee during your visit and any remaining balance can be paid by cash, check or credit card.

Please take a moment to review our Your First Visit page for helpful information regarding your child's initial visit to our office. We understand that most parents are nervous about how their child is going to react at his or her first dental visit, and we are here to help make it as easy and stress-free as possible. Our goal is for all our new patients to have a fun, exciting, and educational visit. We are committed to providing the most positive dental experience we can for your child. This is your child's first visit to our office and we want it to be an awesome one!

Again, we welcome you and your family to our practice and look forward to seeing all of you soon!

Smiles,

Dr. Hargleroad and Team

2105 Bighorn Road, Suite 202 • Fort Collins, CO 80525
www.fckidsdentist.com
(970) 493-2254 • Fax (970) 493-0940

**PATIENT REGISTRATION**

**Patient Information:**

First Name: _____ Last Name: _____ Middle Initial: ___

Preferred Name: _____

Address 1: _____ Address 2: _____

City: _____ State/Zip: _____ Sex: ☐ Male ☐ Female

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Soc. Sec: _____

E-mail: _____ Leave Message: ☐ Home ☐ Cell ☐ Email

Preferred Pharmacy: _____

**Responsible Party:**

First Name: _____ Last Name: _____ Middle Initial: ___

Same as above

Address 1: _____ Address 2: _____

City: _____ State/Zip: _____

Home Phone: _____ Work Phone:_____ Cell Phone: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic.: _____

E-mail: _____ Leave Message: Home ☐ Cell ☐ Email

*Please list any relative(s) of patient with whom Medical and/or billing information can be shared*:

**Authorized Person(s):**

First Name: _____ Last Name: _____ Home Phone: _____

Relation to Patient: _____

**Primary Insurance Information:**

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec/ID#: _____ Insured Birth Date: _____ Group #:_____

Medicaid ID: _____ CHP ID: _____

Employer: _____ Ins. Company: _____

Address 1: _____ Address 1: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

**Secondary Insurance Information:**

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec/ID#: _____ Insured Birth Date: _____ Group #:_____

Employer: _____ Ins. Company: _____

Address 1: _____ Address 1: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Who is responsible for making appointments? _____

Please provide a friend or relative who can be contacted in case of emergency:

NAME: _____ RELATION: _____ PHONE: _____

*Who may we thank for referring you to our office?* _____

# DENTAL HISTORY

Why is the patient seeking dental care? _____.
Is this the patient's first visit to the dental office? Y ◯ N ◯
If no, give date of last visit: _____.
Are you anxious about your child's dental care? Y ◯ N ◯
Has either parent had a lot of tooth decay? Y ◯ N ◯

Has the patient had any of the following dental problems?
Injuries to the mouth or head? Y ◯ N ◯
Toothaches? Y ◯ N ◯
Abscesses (gum boils)? Y ◯ N ◯
Does your child have fluoride in drinking water? Y ◯ N ◯
Does your child use fluoride toothpaste? Y ◯ N ◯
Does the child ever sleep with their bottle or sippy cup? Y ◯ N ◯
If yes, with milk/juice? Y ◯ N ◯ or with water? Y ◯ N ◯
At what age was bottle or breast feeding stopped? _____.
How often are the child's teeth brushed? _____.
Who brushes the child's teeth? _____.
Do child's teeth get flossed? Y ◯ N ◯ If yes, by who? _____
Does child eat sugar-coated cereal for breakfast? _____.
Does child eat more than 3 meals and 2 snacks per day? _____.
Has the patient had orthodontic treatment in the past: Y ◯ N ◯ or present: Y ◯ N ◯
If so, who is the provider: _____.

| **DOES THE PATIENT HAVE ANY OF THE FOLLOWING HABITS?** | **Past** | | **Present** | | |
|---|---|---|---|---|---|
| Tooth grinding | Y ◯ | N ◯ | Y ◯ | N ◯ | (?) ◯ |
| Cheek biting | Y ◯ | N ◯ | Y ◯ | N ◯ | (?) ◯ |
| Tongue thrusting | Y ◯ | N ◯ | Y ◯ | N ◯ | (?) ◯ |
| Mouth breathing or snoring while sleeping | Y ◯ | N ◯ | Y ◯ | N ◯ | (?) ◯ |
| Eating disorder | Y ◯ | N ◯ | Y ◯ | N ◯ | (?) ◯ |
| Finger or thumb sucking | Y ◯ | N ◯ | Y ◯ | N ◯ | (?) ◯ |
| Gum chewing | Y ◯ | N ◯ | Y ◯ | N ◯ | (?) ◯ |
| Does your child drink soda pop on a daily basis | Y ◯ | N ◯ | Y ◯ | N ◯ | (?) ◯ |
| Does your child drink juice on a daily basis | Y ◯ | N ◯ | Y ◯ | N ◯ | (?) ◯ |

Other (specify) _____.

**SOCIAL AND BEHAVIORAL HISTORY**

Do you think the patient will cooperate for dental treatment? Y ◯ N ◯ (?) ◯
Has the patient had a bad or fearful dental or medical experience? Y ◯ N ◯
If your child attends school, where do they attend? _____
Is there any additional information we should know?
If yes, comment _____

Comments: _____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**SIGNATURE OF PATIENT, PARENT OR GUARDIAN** _____ **DATE** _____.

# MEDICAL HISTORY

**Patient Name:** _____ **Birth Date:** _____

Although dental personnel primarily treat the area in and around the patient's mouth, the mouth is a part of the entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Primary Care Physician: _____ Phone Number: _____
Has the patient ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Has the patient had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Please list all medications that the patient takes routinely or occasionally: _____
Is the patient taking any herbal supplements? ☐ Yes ☐ No If yes, please explain: _____
Is the patient on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Are the patient's immunizations up to date? ☐ Yes ☐ No ☐ (?) If no, please explain: _____

Is the patient allergic to any of the following?

| | | | | |
|---|---|---|---|---|
| ☐ Aspirin | ☐ Advil / NSAIDS | ☐ Codeine | ☐ Penicillin | ☐ Sulfa Drugs |
| ☐ Latex | ☐ Local Anesthetics | ☐ Metal | ☐ Acrylic | ☐ Foods |
| ☐ Other | If yes, please explain: | | | |

Does the patient smoke or use smokeless tobacco or marijuana products? ☐ Yes ☐ No If yes, please explain: _____
Does the patient use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

WOMEN ONLY: Are you:
Pregnant / trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

**Does the patient have or has he / she had any of the following:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| AIDS / HIV Positive | Y ☐ N ☐ | Anaphylaxis | Y ☐ N ☐ | Anemia | Y ☐ N ☐ | Arthritis / Gout | Y ☐ N ☐ | | |
| Artificial Heart Valve | Y ☐ N ☐ | Artificial Joint | Y ☐ N ☐ | Asthma | Y ☐ N ☐ | Attention Deficit Disorder/ Hyperactivity Disorder | Y ☐ N ☐ | | |
| Autism Spectrum Disorder | Y ☐ N ☐ | Birth Defects / Genetic Disorders | Y ☐ N ☐ | Blood Disease | Y ☐ N ☐ | | | | |
| Breathing Problem | Y ☐ N ☐ | | | Cancer | Y ☐ N ☐ | Blood Transfusion | Y ☐ N ☐ | | |
| Cerebral Palsy | Y ☐ N ☐ | Bruise Easily | Y ☐ N ☐ | Chest Pains | Y ☐ N ☐ | Celiac Disease | Y ☐ N ☐ | | |
| Cold Sores / Fever Blisters | Y ☐ N ☐ | Chemotherapy | Y ☐ N ☐ | Cortisone Medicine | Y ☐ N ☐ | Cleft Lip and/or Palate | Y ☐ N ☐ | | |
| Developmental Disabilities | Y ☐ N ☐ | Congenital Heart Disorder | Y ☐ N ☐ | Drug Addiction | Y ☐ N ☐ | Depression | Y ☐ N ☐ | | |
| Emphysema | Y ☐ N ☐ | Diabetes | Y ☐ N ☐ | Excessive Bleeding | Y ☐ N ☐ | Easily Winded | Y ☐ N ☐ | | |
| Fainting Spells / Dizziness | Y ☐ N ☐ | Epilepsy or Seizures | Y ☐ N ☐ | Frequent Diarrhea | Y ☐ N ☐ | Excessive Thirst | Y ☐ N ☐ | | |
| Glaucoma | Y ☐ N ☐ | Frequent Cough | Y ☐ N ☐ | Hay Fever | Y ☐ N ☐ | Frequent Headaches | Y ☐ N ☐ | | |
| Heart Murmur | Y ☐ N ☐ | Growth Problems | Y ☐ N ☐ | Heart Trouble/Disease | Y ☐ N ☐ | Heart Attack / Failure | Y ☐ N ☐ | | |
| Hepatitis A | Y ☐ N ☐ | Heart Pacemaker | Y ☐ N ☐ | Herpes | Y ☐ N ☐ | Hemophilia | Y ☐ N ☐ | | |
| High Cholesterol | Y ☐ N ☐ | Hepatitis B or C | Y ☐ N ☐ | Hypoglycemia | Y ☐ N ☐ | High Blood Pressure | Y ☐ N ☐ | | |
| Jaundice | Y ☐ N ☐ | Hives or Rash | Y ☐ N ☐ | Leukemia | Y ☐ N ☐ | Irregular Heartbeat | Y ☐ N ☐ | | |
| Low Blood Pressure | Y ☐ N ☐ | Kidney Problems | Y ☐ N ☐ | Mitral Valve Prolapse | Y ☐ N ☐ | Liver Disease | Y ☐ N ☐ | | |
| Oppositional Defiant Disorder | Y ☐ N ☐ | Lung Disease | Y ☐ N ☐ | Parathyroid Disease | Y ☐ N ☐ | Obsessive Compulsive Disorder | Y ☐ N ☐ | | |
| Radiation Treatments | Y ☐ N ☐ | Pain in Jaw Joints | Y ☐ N ☐ | Renal Dialysis | Y ☐ N ☐ | Psychiatric Care | Y ☐ N ☐ | | |
| Rheumatism | Y ☐ N ☐ | Recent Weight Loss | Y ☐ N ☐ | Sensory Integration Disorder | Y ☐ N ☐ | Rheumatic Fever | Y ☐ N ☐ | | |
| Sickle Cell Disease or trait | Y ☐ N ☐ | Scarlet Fever | Y ☐ N ☐ | | | Shingles | Y ☐ N ☐ | | |
| Stroke | Y ☐ N ☐ | Sinus Trouble | Y ☐ N ☐ | Spina Bifida | Y ☐ N ☐ | Stomach / Intestinal Disease | Y ☐ N ☐ | | |
| Tuberculosis | Y ☐ N ☐ | Swelling of Limbs | Y ☐ N ☐ | Thyroid Disease | Y ☐ N ☐ | Tonsillitis | Y ☐ N ☐ | | |
| Vision problems | Y ☐ N ☐ | Tumors or Growths | Y ☐ N ☐ | Ulcers | Y ☐ N ☐ | Venereal Disease | Y ☐ N ☐ | | |

Has the patient ever had any serious illness not listed? Yes No If yes, please explain: _____

Comments: _____

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in medical status.*

**Signature of Patient, Parent, or Guardian:** **Date:**

**Jennifer K. Hargleroad DDS MS Professional LLC**

*2105 Bighorn Drive, Suite 202*
*Fort Collins, CO 80525*
*www.fckidsdentist.com*
*(970) 493-2254*

# Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

## Your Rights

**You have the right to:**

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

## Your Choices

**You have some choices in the way that we use and share information as we:**

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

## Our Uses and Disclosures

**We may use and share your information as we:**

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

## Your Rights

**When it comes to your health information, you have certain rights.**
This section explains your rights and some of our responsibilities to help you.

| | |
|---|---|
| **Get an electronic or paper copy of your medical record** | • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.<br>• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. |
| **Ask us to correct your medical record** | • You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.<br>• We may say "no" to your request, but we'll tell you why in writing within 60 days. |
| **Request confidential communications** | • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br>• We will say "yes" to all reasonable requests. |
| **Ask us to limit what we use or share** | • You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.<br>• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. |
| **Get a list of those with whom we've shared information** | • You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.<br>• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
| **Get a copy of this privacy notice** | • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
| **Choose someone to act for you** | • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.<br>• We will make sure the person has this authority and can act for you before we take any action. |
| **File a complaint if you feel your rights are violated** | • You can complain if you feel we have violated your rights by contacting us using the information on page 1.<br>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**<br>• We will not retaliate against you for filing a complaint. |

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

| | |
|---|---|
| **In these cases, you have both the right and choice to tell us to:** | • Share information with your family, close friends, or others involved in your care<br>• Share information in a disaster relief situation<br>• Include your information in a hospital directory<br>*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* |
| **In these cases we *never* share your information unless you give us written permission:** | • Marketing purposes<br>• Sale of your information<br>• Most sharing of psychotherapy notes |
| **In the case of fundraising:** | • We may contact you for fundraising efforts, but you can tell us not to contact you again. |

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

| | | |
|---|---|---|
| **Treat you** | • We can use your health information and share it with other professionals who are treating you. | ***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.* |
| **Run our organization** | • We can use and share your health information to run our practice, improve your care, and contact you when necessary. | ***Example:*** *We use health information about you to manage your treatment and services.* |
| **Bill for your services** | • We can use and share your health information to bill and get payment from health plans or other entities. | ***Example:*** *We give information about you to your health insurance plan so it will pay for your services.* |

*continued on next page*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

| | |
|---|---|
| **Help with public health and safety issues** | • We can share health information about you for certain situations such as:<br>  • Preventing disease<br>  • Helping with product recalls<br>  • Reporting adverse reactions to medications<br>  • Reporting suspected abuse, neglect, or domestic violence<br>  • Preventing or reducing a serious threat to anyone's health or safety |
| **Do research** | • We can use or share your information for health research. |
| **Comply with the law** | • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. |
| **Respond to organ and tissue donation requests** | • We can share health information about you with organ procurement organizations. |
| **Work with a medical examiner or funeral director** | • We can share health information with a coroner, medical examiner, or funeral director when an individual dies. |
| **Address workers' compensation, law enforcement, and other government requests** | • We can use or share health information about you:<br>  • For workers' compensation claims<br>  • For law enforcement purposes or with a law enforcement official<br>  • With health oversight agencies for activities authorized by law<br>  • For special government functions such as military, national security, and presidential protective services |
| **Respond to lawsuits and legal actions** | • We can share health information about you in response to a court or administrative order, or in response to a subpoena. |

*We do not create or manage a hospital directory.*
*We do not create or maintain psychotherapy notes at this practice.*

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

*Effective date: June 1, 2005. Revised: July 1, 2016.*

**This Notice of Privacy Practices applies to the following organizations.**

*Our entity is not a part of an organized health care agreement.*

*You will be asked for an electronic signature at your child's dental appointment to acknowledge that you have read and understand this Notice of Privacy Practices and have asked questions about anything that is unclear and that you are satisfied with the answers you have received.*

*Privacy official: Jennifer K. Hargleroad DDS MS, (970) 493-2254, doctor@fckidsdentist.com*

# MEDICAL INFORMATION RELEASE FORM

## *Patient Name(s)* _____

I authorize the release of all medical information, including records and insurance claims, to the following (please mark all that apply).

☐ Name: _____

Circle Relation to Patient: mother/father/step mother/step father

☐ Other (e.g. aunt, grandparent, legal guardian): Name: _____

Relation to patient_____

☐ Treating Orthodontist or other coordinating Health Care Professionals

☐ Information is not to be released to anyone other than myself

I **DO NOT** authorize this information to be disclosed in the following ways (please mark all that apply).

☐ Verbal ☐ Fax ☐ Electronic Mail ☐ Text

***Messages***: I give authorization to be reached by the office and Lighthouse (our automated patient communication system) through the following options (please update and mark all that apply):

☐ home _____
☐ work _____
☐ cell _____
☐ e-mail _____
☐ text _____

If unable to reach me:

☐ you may leave a detailed voice message
☐ you may leave a message with my spouse
☐ please leave a message asking me to return your call
☐ Other_____

**This *Release of Information* will remain in effect until terminated by me in writing, and I release Dr. Jennifer K Hargleroad DDS, MS from any and all state or federal statutes relating to patient privacy.**

Print Name _____ Relation to Patient _____

Signature _____ Date _____

# NON LEGAL GUARDIAN PATIENT ESCORT FORM

*A legal guardian who wishes to have their child be accompanied by a person other than a legal guardian, please complete the section below.*

## *Patient Name(s)* _____

I, _____, the parent/legal guardian authorize my child to be escorted to his/her dental appointment by_____. I authorize this person to provide consent for any proposed dental treatment and to provide updated medical history information for my child. I also authorize this person to receive financial information regarding my account.

I authorize Jennifer K. Hargleroad DDS MS PLLC to examine, take radiographs, perform dental cleaning and apply fluoride. I also authorize the doctor to perform any proposed dental treatment including, but not limited to, stainless steel crowns, fillings, extractions, and the administration of local anesthesia and nitrous oxide. I also authorize any necessary treatment in the event of a medical emergency.

Escort Name_____

Relationship to Patient_____

Phone number of parent/legal guardian_____
***Please be available by phone during the appointment

Signature of parent/legal guardian_____

Printed Name of parent/legal guardian_____

Date of signature_____

| *Office Use Only:* |
| --- |
| |

# AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

---

TO: _____ PATIENT NAME:_____

FAX: _____ DOB: _____ SSN:_____

RELEASE TO:_____

---

*I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):*

**INFORMATION REQUESTED:**

- ☐ Copy of complete dental chart
- ☐ Copy of dental x-rays
- ☐ All treatment rendered
- ☐ Others (e.g. models—describe)

**DATES COVERED:**

*Limited to treatment dates and for condition described below:

_____

---

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

☐ Transfer of Records ☐ Second Opinion

☐ Other, please explain_____

---

**AUTHORIZATION:** *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on_____(date supplied by patient; or ☐ if revoked in writing by patient; or ☐ 180 days from the date hereof; or ☐ under the following conditions:_____.*

---

**OTHER CONDITIONS:** a COPY of this Authorization or my signature thereon ☐ may, or ☐ may not be used with the same effectiveness as an original.

_____
Patient Name (Print)

_____ _____
Person authorized to sign for patient State how authorized

_____ _____
Signature Date

Jennifer K. Hargleroad, DDS, MS
Professional LLC
Board Certified Pediatric Dentistry

## APPOINTMENT POLICIES

We would like to thank you in advance for your understanding. Your cooperation in these matters allows us to serve you and your family better.

- For your comfort, one parent or accompanying adult is welcome but not required to accompany your child to the operatory. However, for the safety and privacy of other patients, **all others**, including children who are not scheduled at this appointment, are asked to remain in the reception area. Young children in the reception room will need a supervisory adult.
- Please make every effort to keep your child's appointment at the reserved time. Kept appointments help us serve you better. To provide the best treatment to your child in a timely way, it is imperative that we provide the proper number of supporting team members and reserve adequate treatment time. A last-minute change or failed appointment means the preparation procedures as well as the reserved time are wasted. Please notify our team 48 hours or more prior to your reserved appointment time so that this time may be offered to another family. If our team is notified less than 48 hours in advance, a $10 fee will be charged.
    - We reserve the right to terminate the patient-provider relationship if there are three or more failed appointments.
    - This policy differs for sedation and general anesthesia appointments and specific instructions will be given at the consultation.
- To see our patients in a prompt manner at reserved appointment times, if you are more than 10 minutes late to the scheduled appointment time, we will try our best to see our child, but you may be asked to reschedule the appointment. After ten minutes the appointment is considered failed is subject to the $10 failed appointment fee.
- Food and drink are discouraged from being brought to appointments due to potential allergies of other clients. Food and drink are expressly prohibited in the treatment areas.
- For the safety of our clients with allergies, we can only allow registered service animals in our facility. Documentation is required.

***Continued***

Jennifer K. Hargleroad, DDS, MS
Professional LLC
Board Certified Pediatric Dentistry

- The use of cell phones for conversation and texting is prohibited in the operatories. The conversations carried on by others present in the clinical area are distracting to children, preventing us from close, careful communication with each patient.
- Photography and videography are prohibited in the operatories without express, written consent and assent of all those present in the room.
- A parent or legal guardian must accompany the patient to appointments.
- Verbal consent will be obtained by a team member for any preventative, diagnostic or emergency services. (ie. exams, radiographs, prophylaxis, fluoride treatments, sealants)
    - Your signature to this policy acknowledges the consent for these procedures.
    - Please notify a front office team member if you would like to sign a written consent for these procedures and it will be provided and obtained.
- A written, electronically signed consent will be obtained for all other procedures.
    - A copy will be provided for your records upon request.
- These consents for treatment shall remain in full force and effective until cancelled by either party. Such a cancellation must be in writing and in no way relinquishes responsibility of the current balance on the account.

**Signature** **Date**

_____ _____

**Printed Name**

_____

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Jennifer K. Hargleroad, DDS, MS
Professional LLC
Board Certified Pediatric Dentistry

**FINANCIAL AGREEMENT**

To reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with a front office team member. We are dedicated to providing the best possible care and service to your child and regard your complete understanding of our financial policies as an essential element of care and treatment. Please sign and complete the bottom of this form.

- **Payment Policy**
  - Payment is due at the time of treatment and may be made by cash, check, Mastercard, Visa, Discover or American Express.
  - All estimated patient responsibility charges and deductibles are due at the time of treatment.
    - For sedation and general anesthesia cases, these anticipated fees are due when the appointment date and time is reserved for the procedure.

- **Insurance Policy**
  - Our team will be happy to assist you in completing the necessary forms for this important benefit. If your insurance allows you to assign benefits to our office, we will file a claim on your behalf.
  - Since all insurance companies, plans and policies differ, we ask that you inform our team of the benefits surrounding your policy. We will make every effort to base anticipated co-payments on this information.
  - Please keep in mind that your policy is an agreement between you and your insurance company, not your insurance company and our office.
  - It is your responsibility to inform our office of any changes in insurance benefits two weeks prior to your reserved appointment time.
  - Upon request and prior to any restorative appointments, a predetermination of benefits can be submitted to your insurance company to give you an estimate of patient responsibility expenses for the proposed treatment. This is not a guarantee of payment by your insurance company. Most insurance companies need an average of two weeks to process this predetermination.
  - Insured patients are expected to pay any estimated copayments and deductibles when treatment is rendered.
  - Any amount not covered by insurance one processed is due within thirty days.

- **Monthly Billing Statements**
  - We do not routinely send billing statements, as all payments are due at the time of treatment. If an account balance is present after any insurance benefits are processed, a courtesy billing statement will be sent electronically to the email address of the guarantor of the account.

***Continued***

- A $5.00 monthly service fee will be added to each additional statement that is required to be sent.
- Uncollected balances past 90 days are subject to collection agency and legal action. Any additional collection and/or legal expenses associated with the collection of an outstanding balance are the responsibility of the guarantor for the account.
  - This will also lead to the termination of the provider and patient relationship.
- The responsible party (guarantor) of the account is the parent or legal guardian that brings the child in for the dental visit. This is also independent of what a divorce decree may state. Regardless of whom the judge deemed financially responsible for dental services, the adult accompanying the child is responsible for payment of services rendered to the patient. Reimbursement must be made between the divorced parents. We will not intervene.

- **Changes to anticipated treatment and sedation/anesthesia services**
  - At times, the recommended treatment may change during the procedure. We try to anticipate these possible changes as much as we are able based on previous experiences and discuss the possibilities prior to the appointment. However, some of these occurrences are not anticipated, yet require being addressed. We will do our best to communicate treatment changes during the appointment. You will be financially responsible for any changes or additions to the treatment.
  - If sedation or general anesthesia is required, additional payment policies will apply, and these will be reviewed prior to the provision of services.

- **Missed Appointment and Cancellation Fees**
  - If our office team is not notified within 48 hours prior to any reserved appointment time, a $10 missed appointment fee of $10 per patient will be collected prior to rescheduling the appointment.

***I have read and understand the appointment policy of the practice and I agree to be bound by its terms and conditions. I also understand that such terms may be amended from time to time by the practice.***

**Signature** **Date**

_____ _____

**Printed Name**

_____