Just4KidzDentistry
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NOTICE OF PRIVACY PRACTICES:
Just4KidzDentistry, LLC, hereafter referred to as "Practice", is committed to preserving the privacy and confidentiality of your health information. The Notice of Privacy Practices describes how we may use and disclose your protected health information, hereafter referred to as "PHI" to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR 164.520. This notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 1/25/13. This notice replaces previous versions of the notice and is effective 9/3/13. You may access or obtain a copy according to the following options: 1.) our website at www.Just4KidzDentitstry.com 2.) contact the office and request a copy to be sent to you by mail or email, 3.) request a copy at the time of your next appointment.

I hereby authorize, as indicated by my signature below, to use and to disclose my child's protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____
Print Name Of Child Your Relationship to Child

_____ _____
Signature of Parent/Guardian Date

Please list authorized persons with whom we may discuss your child's Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed:_____
2. _____ Date Added / Removed:_____
3. _____ Date Added / Removed:_____

LEGAL CONSENT TO MAKE DECISIONS:
As a convenience, we would like to offer you a chance to provide Just4KidzDentistry with a list of individuals that may accompany your child to subsequent visits. Listing an individual will provide them with your legal consent to make both treatment and financial decisions on your behalf. A family member, step-parent, or good friend would have the authority to accompany your child to the dental appointment and make decisions without the need of any additional written or verbal consent. Please provide the names of those individuals that you trust to make such decisions as treatment changes, to make payments and to discuss medical and financial information. We, as a HIPAA compliant healthcare facility, will use our best discretion to maintain all personal information and will only provide the individuals listed with information needed to make a specific decision on your behalf. Information will be provided on a need-to-know basis and we will not allow these individuals to have access to your child's dental record. We simply want to make treating your child in our facility as convenient as possible for you. If there are no individuals listed, patients under the age of 18 must always be present with a parent or legal guardian.

1. _____ Relationship:_____
2. _____ Relationship:_____
3. _____ Relationship:_____

As the parent or legal guardian of the patient noted above, I do hereby provide the individuals listed the legal authority to make decisions in my absence. I also understand that these decisions may change or alter previous treatment recommendations or charges that I have already agreed to and that I, as the child's parent or legal guardian, am ultimately responsible for any new charges incurred as a result of treatment decisions made by any individual listed above.

_____ _____
Signature of Parent/Guardian Date