



**KAYSVILLE**  
**Pediatric Dental**

## **Notice of Privacy Practices-HIPAA**

### **Acknowledgement of Receipt of Notice of Privacy Practices**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- ❖ Obtain payment from third-party payers.
- ❖ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by your office of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review the Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



# KAYSVILLE Pediatric Dental

## Consent for Treatment

Parents/Guardians: Prevailing dental practice law requires that we ask you to read the following and sign at the bottom.

I am the parent/legal guardian of \_\_\_\_\_  
and I have the legal authority to give consent for dental treatment for  
him/her/them.

- ❖ I give consent to Dr. M. Brandon Jones, DMD and other personnel as they may designate to provide treatment for my child/children named above.
- ❖ I give consent to the use of local anesthetics, nitrous oxide (laughing gas), and other medicines or materials. I give consent to other procedures, including, but not limited to emergency medical procedures, which may be deemed necessary or advisable.
- ❖ The following have been explained to my satisfaction: the procedures, benefits, disadvantages, alternatives, side effects, complications, including possible injuries and/or bruising, as well as the prognosis if no treatment is provided.
- ❖ I understand that, although good results are expected, the possibility and nature of complications cannot always be accurately anticipated in advance and therefore, there is no guarantee expressed or implied as to the result of the treatment or as to cure.
- ❖ I have these questions or concerns: \_\_\_\_\_  
\_\_\_\_\_

I have read and I understand this consent for treatment form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_