WELCOME TO PALM BEACH CHILDREN'S DENTISTRY!

Dear Parent/Guardian,

We are very excited to welcome you to Palm Beach Children's Dentistry! We firmly believe that every child can have a healthy mouth with proper guidance, care, and understanding. I am looking forward to helping you feel confident knowing that you will be receiving the best dental care for your little one. We are looking forward to becoming a part of your child's life and helping them grow into smiles they can be proud of!

YOUR CHILD'S FIRST VISIT AND BEHAVIOR MANAGEMENT INFORMATION

At our office, we do all that we can to create a comfortable, safe, and caring environment for your child. For your child's first visit, we welcome you to accompany your child in the treatment area for the initial meeting. This gives you an opportunity to see our staff at work and how we engage with your child. You will also have the opportunity to meet Dr. Lisa Ameer and speak with her regarding any concerns or questions you may have. After your child is made comfortable in our treatment area, we will then escort you back to our waiting room.

We encourage children over the age of 3 to independently come to the treatment area. From our experience and through research of clinical studies, we have found that children over age 3 tend to cooperate better without a parent present in the treatment area with them. Without the parent present, we are able to create a one-on-one communication with your child, allowing us to make a more positive experience for him or her.

If for any reason your child becomes upset during treatment, please feel confident that we will ask you to join us in the treatment area. If you are asked to accompany your child in the treatment area we request that you play the role as a "silent observer" because the child may become confused if more than one person is trying to speak to him/her at a time.

We promise to do all that we can to work with your child and gain a positive relationship through understanding, guidance, humor, charm, and patience. If these fail, there are other behavior management techniques that can be used to eliminate disruptive behavior and help your child understand procedures.

- **TELL-SHOW-DO:** This technique is used by showing the patient first, what we will do and using simple, fun terms for them to understand each procedure.
- **DISTRACTION:** Sometimes your child may benefit from being distracted before any unpleasant sensation is about to occur by focusing their attention on something else.
- **POSITIVE REINFORCEMENT:** When a patient is cooperating, we like to reward the child with praise, compliments or a prize.
- **VOICE CONTROL:** The attention of a disruptive child is redirected by the change in tone of Dr. Ameer's voice.

We are looking forward to meeting you and your child and if any questions may arise, please feel free to ask us!

Sincerely,

Dr. Lisa Ameer and Her Staff

Palm Beach Children's Dentistry
420 S. State Road 7, Suite 140 □ Royal Palm Beach, FL 33414 □ Phone(561) 798-4998 □ Fax(561)798-4996

Palm Beach Children's Dentistry

420 S. SR 7 Suite 140
Royal Palm Beach, FL 33414
www.palmbeachchildrensdentistry.com
Phone: 561-798-4998

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. • 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. • 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. • 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. • 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. • 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. • 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. • 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/.** • 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 • Share information in a disaster relief situation • Include your information in a hospital directory *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 • Sale of your information • 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:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • 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:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • 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.

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 as of: October 9, 2013

Dr. Lisa Ameer *Phone: 561-798-4998* *DrAmeer@PBchildrensdentistry.com*

Palm Beach CHILDREN'S DENTISTRY

PATIENT INFORMATION

Patient Name	Date of Birth	Nickname (if any)	Gender (circle one)
			M / F
			M / F
			M / F
			M / F
			M / F

Address _____ City _____ST_____ Zip _____

Home Phone_____

Mother/Legal Guardian:

Name_____

Employer _____

Work Phone _____ DOB: _____

Cell Phone_____

SS#_____

Father/Legal Guardian:

Name_____

Employer _____

Work Phone _____ DOB: _____

Cell Phone_____

SS#_____

Parents Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Which cell phone number do you prefer for text message appointment reminders?

Mom's Cell: ☐ Dad's Cell: ☐ Other ☐_____

Please provide an email address for appointment reminders _____

How did you hear about our office? ☐ Internet ☐ Insurance ☐ Driving By ☐ Event ☐ Mailer

☐ Dr. /Person _____ ☐ Other_____

EMERGENCY CONTACT (AFTER PARENTS)

In The Event Of An Emergency, Who Should We Contact?

Name _____ Relationship to Patient _____ Phone_____

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Lisa Ameer and her staff to perform cleanings, exams and place topical fluoride treatments on my child. I request and authorize dental x-rays to be taken on my child as considered necessary by Dr. Lisa Ameer to diagnose and/or treat my child's dental needs. I acknowledge that I have been explained all the behavior management techniques that may be used with my child while experiencing dental treatment. I have been given the opportunity to discuss any questions that I may have.

I am permitted by law (by right as a natural parent, legal adoption, or court order) to provide consent for the dental treatment of this child. (Documentation may be requested from you regarding rights of parental consent for the child).

☐ Yes ☐ No

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Printed Name _____

PLEASE COMPLETE ENTIRE FORM

Patient Name: _____

Child's Physician (Office and Doctor's Name) _____

Phone Number of Physician's Office _____ Date of Last Physical _____

Are Immunizations Up to Date? ☐ Yes ☐ No Is Your Child in General Good Health? ☐ Yes ☐ No

Has Your Child Ever Been Hospitalized or Had Any Kind of Surgery? ☐ Yes ☐ No If so, Please explain and give date _____

_____

Is Your Child **Allergic** to any Antibiotics/Drugs? ☐ Yes ☐ No If Yes, Please Explain What and What Type of Reaction _____

_____

Is Your Child **Allergic** to Anything Else (i.e: latex, dyes, etc)? ☐ Yes ☐ No If Yes, Please Explain What and What Type of Reaction_____

_____

Please check yes or no if your child has been diagnosed or treated for any of the following:

	YES	NO		YES	NO		YES	NO
ASTHMA	☐	☐	HEART DISEASE	☐	☐	BLEEDING DISORDERS	☐	☐
ENIRONMENTAL			TYPE _____			ANEMIA	☐	☐
/SEASONAL ALLERGIES	☐	☐	LIVER DISEASE	☐	☐	TYPE _____		
ADHD/ADD	☐	☐	TYPE _____			SEIZURES/EPILEPSY	☐	☐
AUTISM SPECTRUM			KIDNEY DISEASE	☐	☐	DIABETES	☐	☐
DISORDER	☐	☐	TYPE _____			TYPE _____		
DOWN'S SYNDROME	☐	☐	CANCERS/TUMORS	☐	☐	HEPATITIS	☐	☐
CEREBRAL PALSY	☐	☐	TYPE _____			TYPE _____		
CLEFT LIP/PALATE	☐	☐	PERSONALITY/SOCIAL	☐	☐	AIDS/HIV	☐	☐
MENTAL DELAYS	☐	☐	DISORDERs			SPEECH/HEARING	☐	☐
PHYSICAL DELAYS	☐	☐	VISION PROBLEMS	☐	☐	DIFFICULTIES		
NEUROLOGICAL PROBLEMS	☐	☐	ACID REFLUX/GERD	☐	☐	EATING DISORDERS	☐	☐

OTHER (NOT LISTED) _____

PLEASE ELABORATE ON ANY MEDICAL INFORMATION MARKED _____

Is There Any Significant Family History Of Diseases /Oral Cancers? ☐ Yes ☐ No Explain:_____

Is Your Child Currently Taking Any Medications? ☐ Yes ☐ No If Yes, Please Explain Below

Drug Name _____ Dosage/Frequency _____ Reason _____

Drug Name _____ Dosage/Frequency _____ Reason _____

DENTAL HISTORY

Are There Any Specific Concerns/Questions Regarding Your Child's Mouth/ Teeth?_____

Has Your Child Ever Suffered Any Injuries to The Mouth or Teeth? ☐ Yes ☐ No If Yes, Please Explain _____

_____

Has Your Child Ever Seen a Dentist? ☐ Yes ☐ No If So, Name of Dentist and Date of Last Exam _____

Has your child previously had a negative experience at the dentist? ☐ Yes ☐ No If So, Please Explain_____

_____

Is There Anything You Can Tell Us To Help "Connect" With Your Child?
(i.e: Princesses, Trains, Spiderman, Family dog, etc.)_____

Does your child currently do any of the following? (Please check all that apply):

☐ Breast Feed ☐ Bottle Fee ☐ Grind ☐ Thumb/Finger Suck ☐ Use a Pacifier ☐ NONE

What Type of Water Is Present In Your Home? ☐ Filtered Water (from tap or fridge) ☐ Reverse Osmosis ☐ Well Water ☐ Bottled Water

Does Your Child Use Fluoride Toothpaste? ☐ Yes ☐ No Any Other Forms Of Fluoride? (Rinse, Vitamins, etc.)_____

Palm Beach Children's Dentistry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Revised October 2013

You may refuse to sign this acknowledgment.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Palm Beach Children's Dentistry. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____ _____

Parent/Guardian printed name Relationship to Patient

_____ _____

Parent/Guardian signature Date

_____

Patient's Name

If you have any questions about this form or the attached Notice, please contact our Privacy Official, Dr. Lisa Ameer, D.M.D.

Office Use Only

As Privacy Official, I attempted to obtain the parent/guardian signature on this Acknowledgment but did not because:

- It was emergency treatment ____
- I could not communicate with the patient ____
- The patient refused to sign ____
- The patient was unable to sign because_____ ____

_____

Signature of privacy official

Palm Beach Children's Dentistry

CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

I, _____ hereby authorize Palm Beach Children's Dentistry to use and disclose the entire medical record concerning Patient in accordance with the attached Notice of Privacy Practices (NOPP). I have received a copy of and reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release and hold Practice, its employees and agents harmless from any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

_____ _____

Parent/Guardian printed name Relationship to Patient

_____ _____

Parent/Guardian signature Date

_____

Patient's Name

FINANCIAL POLICY

At our office, we plan to work together to achieve one common goal and that is for our kids to grow up feeling confident about their smiles. We promise to properly communicate all that is needed to obtain that goal, including our financial policy.

Payment in full for office visits and treatment is expected at the time service is rendered. Any patients with dental insurance must provide our office with accurate dental insurance information 2 business days prior to their scheduled dental appointment.

INSURANCE

For In-Network Insurances: Our office can file with **MOST** major PPO Insurances. If any balance remains after the insurance has paid, a statement will be sent to you requesting that you pay the remaining balance.

For Out of Network Insurances: In the event that our office is not a provider for your dental insurance, we will collect payment in full for the services before they are rendered. We will then file the claim(s) as an out-of-network provider for you and have the insurance benefits assigned to you. Your insurance company should then send you reimbursement for the portion they have agreed to cover in their contract with you/the policy holder.

By signing this form, I am authorizing assignment of benefits and payment from my child's dental insurance directly to Lisa Ameer, D.M.D. I also am authorizing Dr. Lisa Ameer to furnish my insurance company with any and all information that may be contained in my child's medical and dental records that relates to procedures performed in the office of Dr. Lisa Ameer. Again, most insurance companies do not tell us EXACTLY what they will pay, so we are giving you our best estimate.

TREATMENT PLANS

Prior to beginning and completing any restorative treatment, we will provide you with the best cost estimate of our total fee, your estimated insurance coverage, and your estimated out-of-pocket fees. Please remember, these are only estimates and may change during the course of treatment. In order to provide your child with the best treatment option, changes in treatment plans may occur. You will be notified prior to any treatment plan modification along with any fee change incurred.

For your convenience, we accept cash, debit cards, and most major credit cards; we do not accept American Express. We cannot accept responsibility for negotiating a disputed claim and allow a maximum of 30 days from time service is rendered for your insurance company to clear account balances. If your insurance company does not pay within 30 days from the date service is rendered, *you will be responsible for full payment*. A late fee of $15 will be charged per month to unpaid balances over 30 days past due. If after 90 days from the date of service and attempts have been made to collect any outstanding balances, parents/legal guardians not fulfilling their financial obligation will be sent to collections.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all cost, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Any questions you have may be directed to our office and we will be happy to assist you. We are looking forward to beginning a wonderful relationship with you and your child!

I have read and understand the above financial policy set forth by Palm Beach Children's Dentistry and agree to be held responsible for the terms and conditions mentioned above.

Signature of parent/ legal guardian:_____ Date:_____

Print Name:_____ Relationship to patient:_____

Patient's Name:_____

Palm Beach CHILDREN'S DENTISTRY
DR. LISA AMEER, PEDIATRIC DENTIST

APPOINTMENT POLICY

Palm Beach Children's Dentistry strives to offer an intimate office setting to all of our patients. When we schedule your family for an appointment, we make sure that you get the attention and treatment you deserve from our staff and try to individualize our time with your child.

We take great care to confirm your appointments:
- We implement a text and emailing system using the information you provide on your child's new patient documents.
- This is a good time to let us know if your scheduling needs or insurance information has changed.
- Two(2) days prior to the appointment a text or email will be sent. If you do NOT respond to the text or email, our office will call to confirm your child's appointment the day before.

Our office requires 2 business days notice of an appointment that needs to be rescheduled. We understand unforeseen circumstances occur and will be glad to extend flexibility at our discretion.

Appointment Policy:
-The **1st time** an appointment is missed or rescheduled less than 2 business days in advance,
- we will make a note on your account and remind you of our appointment policy
-The **2nd time** an appointment is missed or rescheduled less than 2 business days in advance,
- an appointment deposit fee will be incurred to reschedule the appointment. This is considered as a deposit for the time we have allotted for your child to receive quality care.

Appointment Deposit:
Appointment deposits are taken over the phone with Visa, MasterCard, and Discover.
If an appointment deposit has been made for the 2nd time of rescheduling an appointment and the appointment is kept, then the deposit is credited to your account. If the credit remains after 90 days and all insurance claims are settled, then a refund check will be issued to you.

If an appointment deposit has been made for the 2nd time of rescheduling an appointment and the appointment is again missed or rescheduled without 2 business days prior notice, your deposit is forfeited and another appointment deposit will be required to schedule any future appointments for your child.

Deposit Fees:
For a Recall/Check-up appointment, the reschedule deposit fee is $35
For a New Patient appointment, the reschedule deposit fee is $35
For ALL Treatment appointments, the deposit fee is $65. If appointment is cancelled without 24 hour notice on 1 occasion, you will automatically forfeit $35 from the initial deposit and be required to pay an additional $35 to bring deposit back to the required $65 total deposit amount.

Palm Beach Children's Dentistry reserves the right to dismiss any family from the practice who abuses our appointment policy. We thank you in advance for your understanding and cooperation.

I HAVE READ AND UNDERSTAND ALL OF THE PALM BEACH CHILDREN'S DENTISTRY APPOINTMENT POLICY.

Parent/Guardian Printed name_____ Relationship to Patient_____

Parent/Guardian Signature _____ Date_____

Patient's Name(s)_____ _____

Palm Beach CHILDREN'S DENTISTRY
DR. LISA AMEER, PEDIATRIC DENTIST
561-798-4998
420 S. State Rd. 7, Suite 140 | Royal Palm Beach, FL 33414
www.palmbeachchildrensdentistry.com

Permission Form

CHILD'S NAME	DATE OF BIRTH

The purpose of this form is to allow you, the parent, the option of naming other adults to bring your child to the office of Dr. Lisa Ameer D.M.D, for dental evaluations and treatment. By completing this form, you are giving permission for these adults to discuss your child's personal medical/dental history and recommendations with the staff of Dr. Lisa Ameer D.M.D, as needed and to make medical/dental decisions for you regarding the dental care of your child/children. **In addition, the accompanying adult is responsible for financial obligations.**

If there are no adults listed, then your child will only be seen when brought by the parent or legal guardian.

DATE	PARENT'S SIGNED INITIAL	NAME OF ADULT	RELATIONSHIP TO CHILD	***DATE & SIGN*** ONLY WHEN REMOVING PERMISSION

Please note: We will ask to keep Driver's License on file when approved adult accompanies child for visits.

This form may be modified in writing at any time at the request of either parent/legal guardian. To remove an adult from this list, simply draw a line through the adult's name, sign your name and date the time that you make the change in the column to the right, of the box above.

_____ Parent/Guardian Printed Name

_____ Relationship to Patient(s)

_____ Parent/Guardian Signature

_____ Date

Record Release from Palm Beach Children's Dentistry

If you would like us to release your child's records,

Please fill out this form and email to drameer@pbchildrensdentistry.com or

fax it to our office at: (561) 798-4996.

I, _____, am requesting release of my child/children's dental records from Palm Beach Children's Dentistry for the following reason:

_____

Child's Name(s) Date of Birth

_____ _____

_____ _____

_____ _____

Please Note: Per office policy, records will NOT be e-mailed to a personal e-mail address. A hard copy printout of records can be requested. Otherwise, records will be e-mailed to your child's/children's future dental office. Once records are released, your account and future appointments will be inactivated. Your child will no longer be considered a patient of record at Palm Beach Children's Dentistry.

Office/Dentist's Name:_____

Dental Office Address:_____

Email records to:_____

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Printed name Phone number