Dr. Heidi's Kid's Dental Center

43731 N. 15th St. West, Suite C, Lancaster, California 93534
(661) 949-0120 Office • (661) 942-2370 Fax
623 W. Avenue Q, Suite B, Palmdale, California 93551
(661) 224-9333 Office • (661) 224-9330 Fax

Pediatric Dentistry
HEIDI HAME, D.D.S., M.S.

COVID-19 Treatment Consent Form

(Patient)

I, ______________________(the parent), consent to have my child receive treatment from Dr Heidi's kids dental center during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.)

I understand that under the CDC and ADA guidelines, do not recommend proceeding with any treatment that is non-essential at this time.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread. ________(Initial)

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that neither my child or myself do not display or currently have any of the symptoms that are representative of COVID-19, which are outlined above: ________ (Initial)

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival. ______(Initial).

I confirm that neither myself or my child has not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. ________ (Initial).

I confirm, to the best of my knowledge, that me or my child have not had close contact with an individual diagnosed with COVID-19 in the past 14 days._____ (Initial)

Patient Name:________________________________

Parent/Guardian Signature:____

Date:____________________

For Practice Use:
Doctor Signature:____
Date:_________________

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COVID-19 Treatment Consent Form
(Parent)

I, ________________________(the parent), consent to have my child receive treatment from Dr Heidi's kids dental center during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.)

I understand that under the CDC and ADA guidelines, do not recommend proceeding with any treatment that is non-essential at this time.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread. ________(Initial)

I understand that the symptoms listed below are representative of COVID-19:
- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that neither my child or myself do not display or currently have any of the symptoms that are representative of COVID-19, which are outlined above: _______ (Initial)

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival. ______(Initial).

I confirm that neither myself or my child has not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. ________ (Initial).

I confirm, to the best of my knowledge, that me or my child have not had close contact with an individual diagnosed with COVID-19 in the past 14 days._____ (Initial)

Patient Name:________________________________

Parent/Guardian Signature:____

Date:____________________

For Practice Use:
Doctor Signature:____
Date:__________________

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In order to be fair to all of our patients, if you have more than **2 cancelled/missed appointments**, we, regretfully, will no longer be able to provide services to you.

- Management

____

Parent's Signature

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PATIENT REGISTRATION

Child's Name ______________________ (First / Middle / Last)
Cell Phone #1 ______________
Address ______________________ (Street / Apt.)
Cell Phone #2 ______________
______________________ (City / State / Zip)
Home Phone No. ______________
Child's Date of Birth ______________
Soc. Sec. No. ______________
In case of emergency, please notify ______________________ (Name / Phone)
WORK ______________

Person Responsible for Account ______________
Relation ______________
Address ______________________ (Street / Apt.)
Home Phone No. ______________
______________________ (City / State / Zip)
Soc. Sec. No. ______________
Employer ______________________ (Name / Street)
Driver's Lic. No. ______________
______________________ (City / State / Zip)
Date of Birth ______________

Are you presently covered by dental insurance? No____ Yes, one plan only ____ Yes, two plans ____

Name of Insurance Co. ______________
Group No. ______________
Date Coverage Effective ______________
Union or Local ______________
Subscriber Name ______________
Soc. Sec. No. ______________

Name of Insurance Co. ______________
Group No. ______________
Date Coverage Effective ______________
Union or Local ______________
Subscriber Name ______________
Soc. Sec. No. ______________

How did you hear of this office?
Yellow pages ______________
Saw the building ______________
Newspaper ______________
Union local ______________
Referred by ______________

PERMIT FOR TREATMENT OF MINOR

I, being the Parent (or Guardian) of the above-named minor patient, do hereby authorize the performance of dental treatment for this patient including what ever procedures the doctor may judge necessary. I do also authorize and request the administration of such anesthetic(s) as may be deemed advisable by the doctor.

SIGNATURE ______________
DATE ______________
RELATION ______________
WITNESS ______________

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HEALTH HISTORY

Does Patient or Family Member have a Syndrome or Chromosome problem that would prevent them from having Local Anesthetic or Nitrous Oxide? Yes ☐ No ☐

SSN#: ______________

Birthday: ______________

Patient's Name: ______________

I. CHECK APPROPRIATE ANSWERS (Leave blank if you do not understand the question):

Yes	No		
☐	☐	1.	Is your general health good?
☐	☐	2.	Has there been a change in your health within the last year?
☐	☐	3.	Have you been hospitalized or had a serious illness in the last three years? Please explain ______
☐	☐	4.	Are you being treated by a physician now? Please explain ______ Date of last medical exam ___/___/___ Date of last Dental appt. ___/___/___
☐	☐	5.	If yes to 4 above, name of Medical Doctor ______ Phone Number (___) ______
☐	☐	6.	Have you had problems with prior dental treatment? Please explain ______
☐	☐	7.	Are you in pain now?

II. HAVE YOU EXPERIENCED:

Yes	No			Yes	No		
☐	☐	8.	Chest pain (angina)?	☐	☐	19.	Dizziness?
☐	☐	9.	Swollen ankles?	☐	☐	20.	Ringing in the ears?
☐	☐	10.	Shortness of breath?	☐	☐	21.	Headaches?
☐	☐	11.	Recent weight loss, fever, night sweats?	☐	☐	22.	Fainting spells?
☐	☐	12.	Persistent cough, coughing up blood?	☐	☐	23.	Blurred vision?
☐	☐	13.	Bleeding problems, bruising easily?	☐	☐	24.	Seizures?
☐	☐	14.	Sinus problems?	☐	☐	25.	Excessive thirst?
☐	☐	15.	Difficulty swallowing?	☐	☐	26.	Frequent urination?
☐	☐	16.	Diarrhea, constipation, blood in stools?	☐	☐	27.	Dry mouth?
☐	☐	17.	Frequent vomiting, nausea?	☐	☐	28.	Jaundice?
☐	☐	18.	Difficulty urinating, blood in urine?	☐	☐	29.	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

Yes	No			Yes	No			Yes	No	
☐	☐	30.	Heart disease?	☐	☐	41.	AIDS or ARC?	☐	☐	Allergies to penicillin?
☐	☐	31.	Heart attach, heart disease?	☐	☐	42.	Tumors, cancer?	☐	☐	Allergies to local anesthetic?
☐	☐	32.	Heart murmurs?	☐	☐	43.	Arthritis, rheumatism?	☐	☐	Allergies to latex?
☐	☐	33.	Rheumatic fever?	☐	☐	44.	Eye disease?	☐	☐	Asthma?
☐	☐	34.	Stroke, hardening of arteries?	☐	☐	45.	Skin diseases?			
☐	☐	35.	High blood pressure?	☐	☐	46.	Anemia?			
☐	☐	36.	TB, emphysema, other lung diseases?	☐	☐	47.	VD (syphilis or gonorrhea)?			
☐	☐	37.	Hepatitis, other liver disease?	☐	☐	48.	Herpes?			
☐	☐	38.	Stomach problems, ulcers?	☐	☐	49.	Kidney, bladder disease?			
☐	☐	39.	Allergies to: drugs, food, medications?	☐	☐	50.	Thyroid, adrenal disease?			
☐	☐	40.	Family history or diabetes, heart problems, tumors?	☐	☐	51.	Diabetes?			

IV. DO YOU HAVE OR HAVE YOU HAD?

Yes	No		
☐	☐	52.	Psychiatric care?
☐	☐	53.	Radiation treatments?
☐	☐	54.	Chemotherapy?
☐	☐	55.	Prosthetic heart valve?
☐	☐	56.	Artificial joint?
☐	☐	57.	Hospitalization?
☐	☐	58.	Blood transfusions?
☐	☐	59.	Surgeries?
☐	☐	60.	Pacemaker?
☐	☐	61.	Contact lenses?

V. ARE YOU TAKING?

Yes	No		
☐	☐	62.	Recreational drugs?
☐	☐	63.	Drug, medicines, (including Aspirin)? Please list ______
☐	☐	64.	Tobacco in any form?
☐	☐	65.	Alcohol?

VI. WOMEN ONLY

Yes	No		
☐	☐	66.	Are you or could you be pregnant or nursing?
☐	☐	67.	Taking birth control pills?

VII. ALL PATIENTS

Yes	No		
☐	☐	68.	Do you or have you had any other diseases or medical problems NOT listed on this form? Please explain ______

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

PARENT'S SIGNATURE ______________ Dentist's Signature ______________

Date ______________ Date ______________

RECALL REVIEW:

1. PARENT'S SIGNATURE ______________ Date ______
2. PARENT'S SIGNATURE ______________ Date ______
3. PARENT'S SIGNATURE ______________ Date ______

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Pediatric Dentistry
HEIDI HAME, D.D.S., M.S.

INELIGIBLE STATUS LETTER

DATE:

TO: **Dr. Heidi's Kid's Dental Center**

- ❐ 43731 N. 15TH ST. WEST, SUITE C, LANCASTER, CA 93534
- ❐ 623 W. AVENUE Q, SUITE B, PALMDALE, CA 93551

IF IT SHOULD BE DETERMINED THAT I AM NOT ELIGIBLE FOR BENEFITS THROUGH MY INSURANCE COMPANY FOR DENTAL: OR ANY RETROACTIVE TERMINATION.

I, ____________________ AGREE TO PAY HEIDI'S CHILDREN'S DENTAL CENTER, INC. THE FULL AMOUNT OF THE SERVICES RENDERED TO MY SON/DAUGHTER ON ____________________, 20___.

NAME: ____________________

ADDRESS: ____________________

____

TELEPHONE NUMBER: ____________________

SIGNATURE: ____________________

DONNELL PRINTING 661-942-1449 JAN 2018

Heidi's Children's Dental Center, Inc.

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Pediatric Dentistry
HEIDI HAME, D.D.S., M.S.

CONSENT

THE UNDERSIGNED HEREBY AUTHORIZES DOCTOR TO TAKE RADIOGRAPHS, STUDY MODELS, PHOTOGRAPHS, OR OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I ALSO AUTHORIZE DOCTOR TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION AND THERAPY THAT MAY BE INDICATED AND FURTHER AUTHORIZE AND CONSENT THAT DOCTOR CHOOSE AND EMPLOY SUCH ASSISTANCE AS DEEMED FIT. I UNDERSTAND THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK.

I UNDERSTAND THAT PAYMENTS FOR DENTAL TREATMENT PROVIDED BY HEIDI'S CHILDREN'S DENTAL CENTER, INC. FOR MY DEPENDENT(S), IS MY RESPONSIBILITY. I ALSO UNDERSTAND AS A COURTESY, HEIDI'S CHILDREN'S DENTAL CENTER, INC. WILL BILL MY INSURANCE AT NO ADDITIONAL CHARGE TO ME. HOWEVER, I AM FULLY AWARE THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES OR BALANCES NOT PAID BY MY INSURANCE COMPANY.

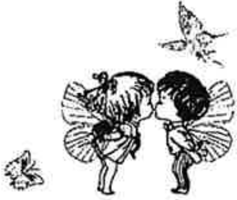
I FURTHER UNDERSTAND THAT 1½% FINANCE CHARGE (18% ANNUALLY) MAY BE ADDED TO ANY BALANCE OVER 90 DAYS, TOGETHER WITH SUCH COLLECTION COSTS AND REASONABLE ATTORNEY FEES AS MAY BE REQUIRED TO COLLECT THIS NOTE.

WE HAVE THE RIGHT TO CHARGE YOU A $35.00 FEE IF AN APPOINTMENT IS NOT CANCELLED WITHIN 24 HOURS. WE WOULD APPRECIATE IT IF YOU WOULD PAY YOUR PORTION IN CASH, MONEY ORDER OR CASHIER'S CHECK.

PARENT'S SIGNATURE ______________________ DATE ______________________

CHILD'S NAME ______________________

DONNELL PRINTING 661-942-1449 APRIL 2016



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INFORMED CONSENT

OUR PEDIATRIC DENTAL OFFICE PHILOSOPHY IS BASED ON OUR COMMITMENT TO PREVENTIVE DENTISTRY AND TO CREATE A SUPPORTIVE AND NURTURING ENVIRONMENT FOR THE CHILDREN AND YOUNG ADULTS UNDER DENTAL CARE. IN PARTICULAR, WE ARE DEDICATED TO PROVIDING SAFE, COMFORTABLE AND QUALITY DENTAL TREATMENT FOR ALL OUR PATIENTS.

CALIFORNIA STATE LAW REQUIRES US TO OBTAIN YOUR INFORMED CONSENT BEFORE WE CAN PROVIDE ANY DENTAL SERVICES FOR YOUR CHILD, OUR MOST IMPORTANT GENERAL OFFICE POLICY IS TO "INFORM BEFORE WE PERFORM". SPECIFICALLY, WE ARE REQUESTING YOUR PERMISSION FOR THE FOLLOWING DIAGNOSTIC AND PREVENTIVE DENTAL PROCEDURES: COMPREHENSIVE CLINICAL EXAMINATION, SELECTED DIAGNOSTIC X-RAYS, THOROUGH PROFESSIONAL CLEANING AND DECAY-FIGHTING FLUORIDE TREATMENT.

PLEASE FEEL FREE TO ASK US ANY QUESTIONS YOU MAY HAVE REGARDING THE PRECEDING INFORMATION OR CONCERNING ANY OTHER ASPECTS OF OUR DENTAL PRACTICE. ADDITIONALLY, YOU MAY WISH TO DISCUSS OUR POLICIES WITH OTHER INDIVIDUALS WHO ARE INVOLVED IN CARING FOR YOUR CHILD.

THEREFORE, I HEREBY GIVE MY CONSENT TO HEIDI'S CHILDREN'S DENTAL CENTER, INC. TO PROVIDE MUTUALLY AGREED UPON DENTAL SERVICES FOR MY CHILD. I AM AWARE THAT HEIDI'S CHILDREN'S DENTAL CENTER, INC. SPECIALIZES IN PEDIATRIC DENTISTRY. I FURTHER AGREE THAT THIS CONSENT SHALL REMAIN IN FULL FORCE UNLESS WITHDRAWN IN WRITING BY THE PERSON WHO HAS SIGNED BELOW ON BEHALF OF THE MINOR PATIENTS OR THEMSELVES.

____________________ PRINT PATIENT'S NAME	____________________ YOUR SIGNATURE
____________________ PATIENT'S AGE	____________________ PRINT YOUR NAME
	____________________ DATE

DONNELL PRINTING 661-942-1449 APRIL 2015

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Pediatric Dentistry
HEIDI HAME, D.D.S., M.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

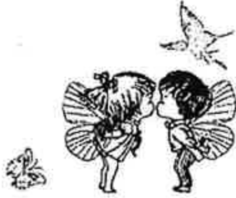
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.



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National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.______ for each page, $______ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: ________________________________

Telephone: ____________________ Fax: ____________________

E-mail: ________________________________

Address: ________________________________

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

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Pediatric Dentistry
HEIDI HAME, D.D.S., M.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____________________

Address: ____________________

Telephone: ____________________ E-mail: ____________________

Patient #: ____________________ Social Security #: ____________________

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: ____________________

Telephone: ____________________ Fax: ____________________

E-mail: ____________________

Address: ____________________

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ____________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____________________

Relationship to Patient: ____________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Dr. Heidi's Kid's Dental Center

43731 N. 15th St. West, Suite C, Lancaster, California 93534
(661) 949-0120 Office • (661) 942-2370 Fax
623 W. Avenue Q, Suite B, Palmdale, California 93551
(661) 224-9333 Office • (661) 224-9330 Fax

Pediatric Dentistry
HEIDI HAME, D.D.S., M.S.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ____________________

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Dr. Heidi's Kid's Dental Center

PATIENT ARBITRATION

Article 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical service rendered under this contract was unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to the treatment or services provided, including but not limited to any spouse, children (born or unborn), heirs, legatees, devises, Executors or Administrators of the Patient or their respective Estates.

All claims against the health care provider, physician, surgeon, dentist, and/or any partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated, including without limitation, claims for loss of consortium, wrongful death, wrongful life, emotional distress, or punitive damages. Health care provider reserves all rights to collect any fees by filing an appropriate legal court action without waiver or invalidation of this contract.

A Demand for Arbitration must be in writing and served on all parties. Within 30 days after service, each party shall select one (party) arbitrator. Within 30 days thereafter, each party arbitrator shall agree on a neutral third arbitrator. Each party shall be responsible for their own attorneys' fees and costs, their party arbitrator fees and costs and their pro-rata share of the neutral, being that Petitioner and Respondent, respectively, will be responsible for one-half of the neutral arbitrator's fees and costs, regardless of the number of each Petitioner or Respondent. In the alternative, the Petitioner may opt to have a single arbitrator, agreed upon by the Parties, provided that the Petitioner agrees, in writing, to limit all damages to amount provided in Civil Code § 3333.2(b).

All laws of California Civil Procedure shall apply including but not limited to discovery, summary judgment, joinder, intervention, bifurcation and evidence. The Parties may agree to waive such requirements. However, the arbitrator must honor any request for bifurcation upon written demand by either party. The parties further agree that any court action against any non-party shall be stayed pending the arbitration. The Parties further agree that all laws applicable to health care providers shall apply to this arbitration including but not limited to Code of Civil Procedure § 340.5 and 667.7 and Civil Code § 3333.1 and 3333.2.

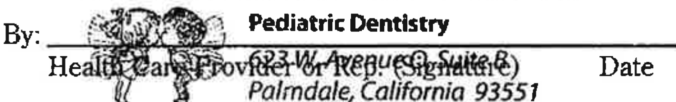
All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding and shall take precedence over any court action. A claim shall be waived and forever barred if (1) on the date notice is received, the claim if asserted in a civil action would be barred by California Law or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any other terms or condition of arbitration not expressly covered herein, such items shall be decided in accordance with California Law. If any provision of this contract is held invalid or unenforceable, the remaining provisions shall remain in full force and effect and shall not be affected by the invalidity of any other provision.

This contract may be revoked by written notice delivered to the health care provider within 30 days after signing. It is the intent of this contract to apply to all medical services rendered under this contract at any time and for any condition while this contract remains in effect. If patient intends this agreement to cover services rendered before the date it is signed, (for example, emergency treatment) patient must initial below:

Effective as of the date of first medical services rendered **X** _______________ (Initials)
Patient, Rep. or Guardian

By signing below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.



By: ______________________________
Health Care Provider or Rep. (Signature) Date

X By: ______________________________
Patient, Rep. or Guardian (Signature) Date

Dr. Heidi's Kid's Dental Center

- ☐ *43731 N. 15th St. West, Suite C, Lancaster, CA 93534*
- ☐ *623 W. Avenue Q, Suite B, Palmdale, CA 93551*

____
Print Patient Name

____
Rep./Guard. Print Name and Relationship