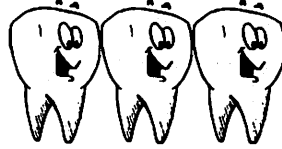


KALISPELL KIDDS PEDIATRIC DENTAL OFFICE
60 FOUR MILE DRIVE, SUITE 10, KALISPELL, MONTANA
406-756-1142



WELCOME

We welcome you and your child to our pediatric dental office. We appreciate the opportunity to apply our care and skill to your child's dental needs. Recognizing that our office is a new experience for both you and your child, we offer the following information about our office.

OUR GOALS

As a pediatric dental office, we are committed to improving the oral health of children by providing your child with thorough and quality care. Pediatric dentists are dentists with an additional 2 years of specialty training. Like pediatricians, pediatric dentists are specially trained to treat the dental needs of infants, children, adolescents and those with special needs. As a pediatric dental office, we take your child's physical, developmental age and any special needs into consideration. When treating your child, we want to make sure he/she has a positive dental experience.

APPOINTMENTS

We have learned over the years that the following "tips" promote the most cooperation from children undergoing dental treatment.

1. Younger children (preschoolers) are best seen in the morning
2. We do our best to stay on schedule, but periodically unexpected events cause us to run behind schedule, so we hope you will be understanding during such circumstances.
3. Since we only see children & Adolescents, it is impossible to see everyone before or after school, but we will be happy to sign an "excuse" for school upon request.
4. The appointment time for your child is reserved especially for your child. Should you need to change or cancel the appointment time, please give us at least 24 hours notice so that we may give that appointment time to another patient. If you no show/no call for your child's appointment your child will not be given another appointment for 6 months. We realize that unexpected things happen, but we ask for your assistance in this regard.

We invite you to stay with your child during his/her appointment. Some children do very well with a parent in the room, while some do better without a parent in the room. We encourage you to let your child gain the confidence to come back by himself/herself. For the safety and privacy of all our patients, other children who are not being treated should remain in the reception room with a supervising adult at all times.

RADIOGRAPHS

Depending on need, x-rays are usually taken to determine your child's dental condition. We use state-of-the-art digital radiography, exposing your child to as little radiation as possible.

PAYMENT/DENTAL INSURANCE

We will make every effort to provide a treatment plan that fits both your timetable and your budget. If we receive all of your insurance information on the day of the appointment, we will be happy to file a claim for you; **however 30% of the procedure fee is due at the time of service. If proof of insurance is not provided at the time of service, you will be responsible for the full amount of the dental treatment provided.** Please understand that we file dental insurance as a courtesy to our patients. We do not have a contract with any insurance company. We at no time guarantee what your insurance will pay or not pay. You are responsible for payments NOT covered by insurance. We accept cash, checks, Visa, Mastercard, and American Express. We also have a CareCredit payment plan option. There will be a \$15.00 charge for returned checks.

PLEASE TURN OVER ↓

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AUTHORIZATION

1. I authorize treatment or procedures as, in the opinion of the pediatric dentist, are necessary. The treatment may include: x-rays, cleaning, fluoride, white fillings (composites), silver fillings (amalgams), silver crowns, nerve treatments (pulpotomies), extractions and space maintainers. The type of treatment and materials used are dependant on the location and severity of the cavity/cavities.
2. I authorize the release of any records that are relevant to the processing and payment of dental insurance claims held by the service provider.
3. I authorize electronic submission of dental claims to my insurance company (where applicable).
4. I authorize my child's picture, if deemed appropriate, to be taken for the "No Cavity Club" picture board and his/her name to be printed in the "No Cavity Club Honor Roll" list in the newspaper.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

- Collect personal information for the safe and efficient delivery of dental treatment for my child
- Disclose your child's PHI to healthcare providers consulted who may be involved in your child's treatment both directly and indirectly
- Obtain payment from third party payers

I received, read and understood Kalispell KiDDS' *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my child's PHI. I understand that Kalispell KiDDS 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 _____ have read this letter and understand its content.
print name

Signed _____ Date _____

Relationship to child _____

PLEASE READ OUR BROKEN APPOINTMENT POLICY:

Due to an increasing number of broken appointments, we have had to become more stringent with our broken appointment policy. If your child has a scheduled appointment, we will attempt to call you a day or two before the appointment to remind you, but it is your responsibility to call our office AT LEAST 24 hours in advance if your child cannot make his/her appointment. If your child does not come to his/her appointment or if you call to cancel your appointment LESS THAN 24 hours before the scheduled time, your child will not be given another appointment for 6 months. We understand that there are extenuating circumstances, and we will do everything we can to accommodate your child's needs.

Please initial below that you have read and that you understand the broken appointment policy above.

Kalispell KIDDS

As Required by the Privacy Regulations created as a result of the Health Insurance Portability Act of 1996 (HIPAA).

This Notice Describes How Medical Information About Your Child (as a Patient of this Practice) May Be Used and Disclosed, And How You Can Get Access to This Information. Please Review This Notice Carefully.

A. Our Commitment to Your Child's Privacy

Our practice is dedicated to maintaining the privacy of your child's protected health information (PHI). In conducting our business, we will create records regarding your child and the treatment and services we provide to your child. We are required by law to maintain the confidentiality of your child's PHI. We are also required by law to provide you with this notice of our legal duties and the privacy practices we maintain in our practice concerning your child's PHI. By federal and state laws, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your child's PHI
- Your privacy rights in regards to your child's PHI
- Our obligations concerning the use and disclosure of your child's PHI
- How you can lodge a complaint about how we handle your child's PHI without your approval for certain matters

The terms of this notice apply to all records containing your child's PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your child's records that our practice has created or maintained in the past, and for any of your child's records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If You Have Questions About This Notice, Please

Contact: Cooke Thompson, Office Manager 756-1142

C. We May Use and Disclose Your Child's Protected Health Information (PHI) In the Following Ways

The following categories describe the different ways in which we may use and disclose your child's PHI.

1. Treatment. Our practice may use your child's PHI to treat him/her. For example, we may ask to have laboratory tests and we may use the results to help us reach a diagnosis. We might use your child's PHI in order to write a prescription for your child, or we might disclose your child's PHI to a pharmacy when we order a prescription for your child. Many of the people who work for our practice – including, but not limited to, our dentist, hygienist and assistants – may use your child's PHI in order to treat your child or assist others in your child's treatment. Additionally, we may disclose your child's PHI to others who may assist in your child's care, such as your friends and family members involved in your child's care.

2. Payment. Our practice may use and disclose your child's PHI in order to bill and collect payment for services. For example, we may contact your health insurance company to certify that your child is eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your child's treatment to determine if your insurer will cover, or pay for, your child's treatment. We may also use and disclose your child's PHI to obtain payment from third parties that may be responsible for such costs, such as friends or family members. We may also use your child's PHI to bill you directly for services.

3. Health Care Operations. Our practice may use and disclose your child's PHI to operate our business. As examples, our practice may use your child's PHI to evaluate the quality of care your child receives from us or to train new healthcare workers.

4. Treatment Options. Our practice may use and disclose your child's PHI to inform you of potential treatment options or alternatives.

5. Release of Information to Family/Friends. Our practice may release your child's PHI to a friend or family member that is involved in your child's care, or who assists in taking care of your child. For example, a guardian may ask that a relative take his/her child to the dentist for treatment. This relative may have access to the patient's PHI with the guardian's permission.

6. Disclosures Required by Law. Our practice will use and disclose your child's PHI when we are required to do so by federal, state or local law.

D. Use and Disclosure of Your Child's PHI in Certain Special Circumstances Without Your Approval

The following categories describe unique scenarios in which we may use or disclose your child's PHI without your consent or approval.

1. Public Health Risks. Our practice may disclose your child's PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births or deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products
- Notifying individuals if a product they may be using has been recalled

2. Health Oversight Activities. Our practice may disclose your child's PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general. We may use your child's information to report diseases to the health department.

3. Lawsuits and Similar Proceedings. Our practice may disclose your child's PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We may also disclose your child's PHI in response to a discovery request, subpoena, or other lawful process by another party involved in a dispute, but only if we made an effort to inform you or the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release your child's PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain your agreement
- Concerning a death believed to have resulted from criminal conduct
- Regarding criminal conduct at our office
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or description, identity or location of the perpetrator)

5. Serious Threats to Health or Safety. Our practice may use your child's PHI when necessary to reduce or prevent a serious threat to your child's health and safety or the health and safety of you or the public. Under these circumstances, we will only make disclosures to a person or organization able to prevent the threat.

6. National Security. Our practice may disclose your child's PHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your child's PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

E. Your Rights Regarding Your Child's PHI

You have the following rights regarding your child's PHI that we maintain:

1. Confidential Communications. You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work, or to send communications in a sealed envelope instead of a postcard. In order to request a type of confidential communication, you must make a written request to our Privacy Officer specifying the requested method of contact, or the location you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use and disclosure of your child's PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your child's PHI to only certain individuals involved in your child's care or the payment of your child's care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except otherwise required by law, in emergencies, or when the information is necessary to treat your child. In order to request a restriction in our use or disclosure of your child's PHI, you must make your request in writing to our Privacy Officer. Your request must describe in a clear and concise fashion:

- a) The information you wish restricted
- b) Whether you are requesting to limit our practice's use, disclosure or both; and
- c) To whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of your child's PHI that may be used to make decisions about your child, including patient records and billing records. You must submit your request in writing to Cooke Thompson, Kalispell

KiDDS, 756-1142, in order to inspect and/or obtain a copy of your child's PHI. Our practice may charge a fee for the costs of copying associated with your request.

4. Amendment. You may ask us to amend your child's health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to our Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the reason supporting your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the PHI kept by or for our practice; c) not part of the PHI which you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures that our practice has made of your child's PHI. We are not required to list use of your child's PHI as part of the routine patient care, payment, or health operations in our practice for paper records. Examples of routine patient care, payment or health operations excluded from paper records include: the dentist sharing information with the assistant, the billing department using your information to file your child's insurance claim, and discussion of your child's PHI for purposes of improving our health care delivery system. In order to obtain an accounting of disclosures, you must submit your request in writing to Cooke Thompson, Kalispell KiDDS, 756-1142. All requests for an "accounting of disclosures" must state a time period, which may not be longer than three (3) years for listings to include treatment and payment from electronic records, from the date of request, and may not include dates prior to April 12, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You will be offered a copy on your first visit to our practice. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this notice, ask our front desk or contact our Privacy Officer at 756-1142.

7. Right to File a Complaint. If you believe your child's privacy rights have been violated, you may file a complaint with our practice, or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Cooke Thompson, 756-1142.

To file a complaint with the Secretary of the DPHHS, send a written request to the Office of Civil Rights, 200 Independence Avenue SW, Washington, DC, 20201, or phone (202)619-0257 or toll free (877)696-6775. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not covered by this notice or permitted by applicable law, such as for research or marketing. Any authorization you provide to us regarding use and disclosure of your child's PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your child's PHI for the reasons described in the authorization. Please note, we are required by law to retain records of your child's dental care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer at 406-756-1142.

This Notice of Privacy Practices is effective 1/1/2011.

Child Health Questionnaire

In order to provide a complete dental exam for your child, please answer all of the following questions as completely as possible.

Date _____ Child's First Name _____ M.I. _____ Last Name _____
 Birth Date _____ Age _____ Sex: Male Female

Child's Physician – First Name _____ Last Name _____
 Address _____ Physician's Phone # _____

Date of last physical examination _____
 How is your child's general health? _____
 Has your child had any serious illnesses? Yes / No

If yes, please describe _____
 Has your child ever been hospitalized? Yes / No
If yes, when and for what reason? _____

If your child taking any medications, vitamins and/or natural remedies at this time? Yes / No
If yes, please describe _____

Has your child ever had an allergic reaction to any of the following? (Please circle)
 Dental Anesthetics Antibiotics Food Drugs Latex
If yes, please describe _____

Has your child ever received a blow or injury to his/her head or teeth? Yes / No
 Has your child ever been treated with radiation therapy? Yes / No

Has your child ever had any of the following conditions? (Please check Yes or No for each)

	Y N Age				Y N Age				Y N Age		
	Y	N	Age		Y	N	Age		Y	N	Age
ADD/ADHD				Diabetes				Mentally Challenged			
AIDS/HIV				Hearing Problems				Physically Challenged			
Asthma				Heart Murmur				Pregnancy			
Autism				Heart Problems				Scarlet Fever			
Behavioral Disturbance				Hepatitis				Seizures			
Blood/Bleeding Disorders				Kidney Problems				Stomach Problems			
Cancer				Learning Disability				Tuberculosis			
Cerebral Palsy				Lung Disease				Other (not listed)			

If yes to any of the above, please describe _____

Does your child have any habits we should be aware of, such as... (Please circle)
 Poor eating habits Thumb sucking Pacifier Bottles Other _____

Does your child receive fluoride in: Drinking water at home (city water) Yes / No By Prescription Yes / No
 Has your child had any unpleasant dental experiences? Yes / No

If yes, when? _____
How can we help? _____

Date of last dental examination _____
 Has your child ever had orthodontic treatment? Yes / No

What is the nature of today's visit? (Please circle) Regular exam Emergency

Signature of Parent/Guardian _____ Date _____

Child and Family History

Patient Information

Patient's Name _____ Nickname _____
First Name M.I. Last Name

Date of Birth _____ Sex: Male Female

Is Patient adopted? Yes / No If Yes, Legal Guardian Name _____

Name of School _____ Grade Level _____

Name and Ages of Siblings _____

Are any of these siblings currently patients in this office? Yes / No

Child's Address _____

City _____ State _____ Zip _____

Home Phone Number (____) _____

Favorite Pet or Toy _____ Pet or Toy's Name _____

Who may we thank for referring you? _____

Responsible Party Information

Father's Name _____ Date of Birth _____

Social Security # _____ Email address _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Cell # _____

Place of Employment _____ Occupation _____

Mother's Name _____ Date of Birth _____

Social Security # _____ Email address _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Cell # _____

Place of Employment _____ Occupation _____

Dental Insurance Information

Primary Insurance

First Name of Insured _____ Last Name _____

Insured's Date of Birth _____ ID# _____ Group # _____

Insured's Employer Name _____ Address _____
Street City State Zip

Insurance Plan Name _____

Insurance Address _____ Phone # _____
Street City State Zip

Secondary Insurance

First Name of Insured _____ Last Name _____

Insured's Date of Birth _____ ID# _____ Group # _____

Insured's Employer Name _____ Address _____
Street City State Zip

Insurance Plan Name _____

Insurance Address _____ Phone # _____
Street City State Zip