CONSENT FOR DENTAL PROCEDURES AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. At each examination appointment, we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, and examination of the teeth (hard and soft tissues of the mouth and the bite). Any other treatment needed such as fillings, caps, extractions, etc. will be performed at a separate appointment after obtaining your permission.

1. I hereby authorize and direct Dr. Boling to perform upon my child the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.
2. In general terms, the dental procedures or operation will include:
   - A. Cleaning of the teeth and the application of topical fluoride.
   - B. Application of plastic "sealants" to the grooves of the teeth.
   - C. Treatment of the diseased or injured teeth with dental restoration (filling or caps).
   - D. Removal of one or more teeth.
   - E. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
   - F. Use of local anesthesia, by injection, to numb the teeth worked on: Numbness usually lasts from 1 1/2 to 3 hours. Allergic reactions are rare. Your child will be cautioned to not bite the numb lip and cheek. Please do not tell your child that they are going to get a "shot". We have our special way of informing them of this.
   - G. Use of Nitrous Oxide (laughing gas): This is used to help children relax and feel the injection less. This gas is placed over your child's nose after an explanation is given. Again, this gas is very safe when used in the concentration that we use. The nose piece, as with all treatment, will not be forced on your child.
   - H. Use of behavior management techniques.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage or death. I further authorize Dr. Boling to perform treatment as may be advisable to preserve the health and life of my child.

I hereby state that I have read and understand this consent and the behavior management techniques and that all questions about the procedures have been answered in a satisfactory manner; and I understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental operatories shall be the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or the sharp dental instruments.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

Tell-show-do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

Positive Reinforcement: This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.

Voice Control: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of a command.

Mouth Props: A rubber device is placed in the child's mouth to prevent closing when a child refuses or has difficulty keeping an open mouth.

Sedations: Sometimes medications are used to relax a child who does not respond to other behavior management techniques. These drugs may be administered orally or as a gas (nitrous oxide and oxygen). The child does not become unconscious. Your child will not be sedated without you being further informed and obtaining your specific consent for such procedure.

General Anesthesia: The dentist performs the dental treatment with the child anesthetized in the hospital operating room. Your child will not be given general anesthesia without you being further informed and obtaining your specific consent for such procedure.

Please list all children who may attend our office, sign and date.

Child's Name: _____ **DOB:** _____

Child's Name: _____ **DOB:** _____

Child's Name: _____ **DOB:** _____

Child's Name: _____ **DOB:** _____

Child's Name: _____ **DOB:** _____

Patient / Parent Signature:_____ **Date:**_____

OFFICE POLICIES

- We request that the person accompanying the child not leave the premises until the appointment is over, in the event a question arises regarding the child's appointment.
- Dr Boling, as a courtesy, will accept and file your insurance for you. However, we are only participating providers with Ameritas, Assurant, Aetna, BCBS, Cigna PPO, Delta Dental Premier, DenteMax, Medicaid, United Concordia (Parnet & Concordia Advantage). THIS MEANS YOU ARE RESPONSIBLE FOR THE DIFFERENCE BETWEEN OUR FEES AND THE INSURANCE ALLOWABLE FEE.
- I am aware that some procedures are subject to a deductible. If the deductible has not been met then I will pay this at the time services are rendered.
- If you have a secondary insurance, it does not necessarily mean that this combined insurance will cover our services 100%. It is up to you, the insured, to know how the two dental plans will coordinate benefits.
  Dr. Boling will file your primary dental insurance for you as a courtesy. You will be responsible for filing any additional insurance.
- I hereby agree to assign all insurance payments to Dr. Boling. I am aware that my insurance company may not cover all the professional fees. I hereby agree to pay, within 30 days, any outstanding balance following payment by the insurance company.
- I agree that if the insurance fails to pay Dr. Boling within 30 days of the rendered treatment all fees are due and payable at the time.
- In the event the insurance company pays me, the patient, instead of Dr. Boling, I agree to forward the payment to Dr. Boling.
- In the event a check is returned from a financial institution, a return check fee of $30.00 will be applied.
- In the event of default, I promise to pay legal interest on the indebtedness together with such collection costs as may be required to effect the collection of this note. This means that I may not only be responsible for my total account balance, but also for an additional amount up to 50% of that amount which is the collection agency fee.
- I agree to give the dental office a minimum of five days advance notice of any changes to my dental insurance.

The scheduled appointment is reserved specifically for your child, any changes in this appointment will affect many other patients. If 48 hours notice is not given, we reserve the right to charge a $75.00 broken appointment fee to your account.

We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apologies in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.

Please plan to arrive at least 5 minutes before your scheduled appointment. This will allow time to complete any additional paperwork and see your child on time.

If you arrive late to your appointment, you may be asked to reschedule to the next available appointment time or day.

Broken or missed appointments affect many people. If two (2) broken/missed appointments occur or two (2) cancellations without 48-hour notice, our office reserves the right to NOT schedule any subsequent appointments.

If at any time you have questions, please feel free to ask our staff. We are here to help in any way we can. We appreciate you entrusting your child's dental health to us.

Date:_____

Patient /Guardian/ Parent Signature: _____

Inclement Weather Policy

Lonestar Smiles for Kids makes every effort to see that every visit is comfortable and safe for you and your family. Please be advised that in cases of extreme weather we will follow the Weatherford ISD school guidelines for opening and closing due to inclement weather. If WISD closes, so will our office. If WISD delays school start times, our office will delay opening and all appointments preceding our opening will be called and rescheduled. Appointments that were scheduled for the hours we were closed will be rescheduled when we re-open. Local news stations will also broadcast information about school closing and or delays. Thank you for your consideration in this matter.

Signature_____ Date_____

TO OUR MEDICAID PATIENTS

Please be advised that as a medicaid provider for the state of Texas this office is required to report to your medicaid case worker if you do not keep your dental appointments or if you do not schedule an appointment when treatment has been recommended. If you have any questions, please speak with one of our receptionists.

Signature_____ Date_____