



WELCOME TO YOUR KIDDOS NEW DENTAL HOME! - INTAKE FORM

Patient Name: _____

Patient DOB: _____

Your Name: _____

Relationship to Patient: _____

CANCELLATION POLICY

As a private office, Great Lakes strives to provide quality care in a timely manner. We have reserved a scheduled time solely for the patient with additional time built-in to provide an opportunity for the parent(s) to communicate with us. We believe this strategy will best serve our patients. For each appointment, the staff sets up a treatment room with a block of time that is reserved specifically for you. Before each appointment the doctor spends time reviewing your information and planning your care. We feel that a successful outcome to treatment is the result of combined efforts of both you and this office. At the same time, we do understand that unforeseeable events including emergencies may arise. If you need to cancel or reschedule an appointment, please inform our dental office at least **TWO BUSINESS DAYS** ahead of time. This will enable other patients with urgent dental care requests to fill in the spot.

For any appointment canceled without **TWO BUSINESS DAYS ADVANCE NOTICE** or missed (No Show), NOT due to illness or family emergency, our system counts it as a "broken appointment". For any broken appointment, we reserve the right to perform the following:

- **FIRST broken appointment-** No new appointment within 2 WEEKS.
- **SECOND broken appointment-** No new appointment, same-day appointment only.
(Call the morning of normal business hours to see if we have any openings for that day)
- **THIRD broken appointment-** e will not be able to reschedule any further appointments.

Signature: _____

Date _____

INSURANCE COVERAGE AND FINANCIAL DISCLAIMER

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. We are always available to answer your questions and/or assist you in any way we can. For our patients with dental insurances, as a courtesy, we are happy to bill your insurance on your behalf. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment, there may be a balance remaining after insurance payments. Insurance estimates given by this office are not a guarantee of payment. By accepting treatment, the responsible party assumes responsibility for all charges incurred. Any balance remaining after the insurance payment is received will be the guarantor's responsibility. Payments are due on the day services are rendered. We accept cash, personal checks and all major credit cards (please note all credit cards including HSA/FSA cards are subject to a 3.5% credit card fee). If your account goes 30 days past due, a \$10 per month late fee will be assessed every month until the account is paid in full. If your account is sent to a collection agency or to small claims court, you will be responsible for the additional cost, which could be up to 50% of your outstanding balance.

Signature: _____

Date _____

ACKNOWLEDGEMENT OF RECEIPT OF THIS PRACTICE'S PRIVACY NOTICE (HIPPA)

I acknowledge that I have received, and/or reviewed the notice of the Privacy Practices of Great Lakes Pediatric Dentistry. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of this office's Privacy Practices is posted in the office where I can review it if desired. If the patient representative signs above please describe the relationship to the patient. DOCUMENTATION OF "GOOD FAITH EFFORT".

Signature: _____

Date _____



OFFICE USE ONLY: ACKNOWLEDGEMENT OF RECEIPT OF THIS PRACTICE'S PRIVACY NOTICE (HIPPA)

The patient presented for treatment on this date and was provided this practice's Privacy Notice. A good faith effort was made to obtain written acknowledgement of receipt. A written acknowledgement was NOT obtained because:

- _____ Patient refused to sign, with the reason: _____
- _____ Patient is unable to sign due to: _____
- _____ There was a medical emergency preventing timely signature and an attempt will be made to obtain acknowledgement later.
- _____ Other: _____

Employee: _____ Date _____

OFFICE PHOTOGRAPHY AND VIDEOTAPING POLICY AGREEMENT AND CONSENT

I, _____, hereby acknowledge and agree to the policies outlined by [Dentist Office Name] regarding the use of photography and videotaping within the premises. I understand that the purpose of this policy is to protect the privacy and confidentiality of all patients and staff members in accordance with HIPAA regulations.

Terms and Conditions:

- Prohibition of Photography and Videotaping: I agree not to take any photographs or videotapes within the premises of [Dentist Office Name] without explicit written consent from the management.
- Understanding HIPAA Regulations: I acknowledge that the Health Insurance Portability and Accountability Act (HIPAA) requires the protection of patient privacy and the confidentiality of health information. Any unauthorized photography or videotaping may constitute a breach of HIPAA regulations.
- Consequences of Breach: I understand that any breach of this policy may result in legal action, including but not limited to civil and criminal penalties, as well as potential termination of my relationship with [Dentist Office Name].
- Consent for Official Documentation: I understand that [Dentist Office Name] may, at its discretion, take photographs or videos for official use, such as clinical documentation, training, or marketing purposes. In such cases, my consent will be obtained separately.

Signature: _____ Date _____

SOCIAL MEDIA CONSENT FOR USE OF LIKENESS AND CONTENT

I parent or legal guardian of the minor patient listed on this form, hereby grant permission to Great Lakes Pediatric Dentistry and Tongue Tie Center to use my child's likeness, image, and any content provided by my child, including but not limited to comments, photos, videos, and other materials, on official social media platforms associated with Great Lakes Pediatric Dentistry and Tongue Tie Center. Terms and Conditions:

- Use of Child's Likeness: I understand that my child's likeness, image, and content may be used on [Pediatric Dental Clinic's Name] official social media accounts, including but not limited to platforms such as Facebook, Instagram, Twitter, and others.
- Purpose of Use: I grant permission for the use of my child's likeness and content for promotional, educational, or other purposes related to the pediatric dental clinic's mission and activities.
- No Compensation: I acknowledge that my child will not receive any compensation for the use of their likeness and content on social media.
- Revocation of Consent: I understand that I have the right to revoke this consent at any time by providing written notice to Great Lakes Pediatric Dentistry and Tongue Tie Center. However, any uses of my child's likeness or content that occurred before the revocation will still be valid.

- YES. Consent Confirmation: I have read and understood the terms and conditions outlined in this Pediatric Dental Clinic Social Media Consent Form, and I voluntarily grant permission for the use of my child's likeness and content as described.
- NO. You cannot use my child on social media.

Signature: _____ Date _____

GOOD TIMES, THANKS AGAIN!