WE Smile & Panther Pediatric Dentistry Patient Health Information

Patient Name: _____ Today's Date:_____
Last First MI

Birth Date:_____ Nickname: _____ ☐ Male ☐ Female ☐ Prefer:_____

Health Information

Has the child ever had any of the following? Please check all those that apply:

- ☐ ADD/ADHD
- ☐ Allergy - Food _____
- ☐ Allergy - Drug _____
- ☐ Allergy - Seasonal _____
- ☐ Allergy - Other _____
- ☐ Anemia
- ☐ Asperger Syndrome
- ☐ Asthma
- ☐ Autism
- ☐ Blood Disorder
- ☐ Cancer _____
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Congenital Heart Defect _____
- ☐ Constipation
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Eczema
- ☐ Epilepsy
- ☐ Eye Condition
- ☐ G6PD Deficiency
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Herpes Simplex I or II
- ☐ HIV Positive/AIDS
- ☐ Hormone Deficiency
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Lactose Intolerance
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Measles
- ☐ Mental Disorders _____
- ☐ Mumps
- ☐ OCD (Obsessive Compulsive Disorder)
- ☐ ODD (Oppositional Defiant Disorder)
- ☐ Osteogenesis Imperfecta
- ☐ Pertussis/Whooping Cough
- ☐ Premature: _____weeks
- ☐ Previous Dental Surgery
- ☐ Respiratory Problems _____
- ☐ RSV
- ☐ Rubella
- ☐ Scarlet Fever
- ☐ Sickle Cell Anemia
- ☐ Sickle Cell Anemia Trait
- ☐ Stomach Problems _____
- ☐ Surgeries _____
- ☐ Tuberculosis
- ☐ Unknown medical history due to adoption/foster care
- ☐ Urinary Tract Problems
- ☐ Vitamin Deficiency
- ☐ Xerostomia (dry mouth)

Reason for this visit: _____ Last Dental Visit: _____ What is his/her weight: _____

- Are your child's vaccines (immunizations) up to date? ☐ Yes ☐ No If no, please explain:_____
- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Is your child under the care of a physician for reasons other than well visits? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician or Pediatrician: _____
- List any medications your child is taking:_____
- Does your child have any health conditions that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my child's health to report, I will inform the doctors and staff at the next appointment without fail.

_____ Date: _____
Signature of parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ A patient or family/friend:_____
(name)

☐ School ☐ Work ☐ Dental Office ☐ Pediatrician ☐ Advertising ☐ Social Media

☐ Other/Name _____

WE Smile & Panther Pediatric Dentistry ▪ Patient Registration Information

Patient Name: _____ Birthdate:_____
Last First MI

Address: _____
Street City State Zip

Phone Number:_____ Preferred Language:_____ ☐ Male ☐ Female

Insurance Name:_____ Insurance ID#: _____ ☐ Prefer:_____

Social Security #:_____ Ethnicity:_____ Race:_____

Preferred E-mail Address:_____ Appointment Reminders: ☐ Text ☐ E-mail

Parent or Guardian Information ▪ Responsible Party Information

Parent/Legal Guardian Relationship to Child:_____

Name:_____ Birth Date: _____

Social Security #: _____ ☐ Male ☐ Female ☐Prefer:_____ ☐ Married ☐ Single ☐ Other _____

Phone (Home): _____ (Work): _____ (Cell):_____

Address: _____
Street City State Zip

Employer Name:_____ Occupation:_____

Are you the policy holder? ☐ Yes ☐ No Insurance Name:_____

Contract ID#:_____ Group #:_____

Parent/Legal Guardian Relationship to Child:_____

Name:_____ Birth Date: _____

Social Security #: _____ ☐ Male ☐ Female ☐Prefer:_____ ☐ Married ☐ Single ☐ Other _____

Phone (Home): _____ (Work): _____ (Cell):_____

Address: _____
Street City State Zip

Employer Name:_____ Occupation:_____

Are you the policy holder? ☐ Yes ☐ No Insurance Name:_____

Contract ID#:_____ Group #:_____

Consent: As a condition of your child's treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the parent/guardian for the costs incurred in their child's care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any services provided without previous financial arrangements, must be paid for at the time services are rendered.

Parents who carry dental insurance for their child understand that all dental services provided are charged directly to the patient account and that the parent/guardian is responsible for payment of all dental services. This office will help prepare the patient's insurance claim forms and/or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We can only give an estimate based on our agreement with the insurance company, but any balance unpaid by the company remains the responsibility of the parent/guardian.

In consideration for the professional services rendered to my child by the Doctor, I agree to pay Dr. Kari A. Cunningham, DMD, LLC the value of those services at the time they are rendered, or within fourteen (14) days of billing if credit shall be extended. I further agree that the reasonable value of the services shall be as billed, within the time for payment thereof. Any amount not covered by my insurance plan that lists a "patient responsibility" value, will be paid by me within 14 days of receiving a statement of balance due. I further agree to pay all costs and reasonable attorney fees associated with the collection of any amounts past due related to the services rendered on my child. For outstanding balances of 120 days, I understand that the office will add an additional fee of $30.00 prior to forwarding to the collection agency. I acknowledge and agree to the content above by signing below:

_____

Signature of Parent, Guardian and/or Responsible Party Date Relationship to Patient

Kari A. Cunningham, DMD, LLC – Panther Pediatric Dentistry Policies

Patient Name: _____ Birthdate:_____
Last First MI

1. I have had the opportunity to review a copy of this office's Notice of Privacy Practices and I consent to the use of my and my child's protected health information for treatment, payment, and the healthcare operations of Kari A. Cunningham, DMD, LLC (dba: Panther Pediatric Dentistry) as summarized in the notice of privacy practices.
You may refuse to sign this privacy practices acknowledgement

Signature:_____ ☐ I refuse to sign this privacy practices acknowledgement *(Check if you refuse to sign)*

Date: _____

2. I, the parent/legal guardian may not leave the office of Panther Pediatric Dentistry during my child's dental visit. If I do leave the office area while my child is being seen, I understand that treatment may be stopped and my child may have to be rescheduled for treatment to be completed.

3. Panther Pediatric Dentistry requests that the parent/legal guardian remains in the lobby during the patient's dental visit. Exceptions may be made under certain circumstances and when it is in the best interest of the patient. Parental presence or absence is an accepted and recognized behavior guidance tool of the American Academy of Pediatric Dentistry. The team at Panther Pediatric Dentistry may use the tool to safely, effectively, and efficiently complete treatment.

4. **Missed Appointment Policy:** Panther Pediatric Dentistry requires a 24-hour notice for cancellation of appointments. If a 24-hour notice is not given, it will be counted as a missed appointment.

4a. New patients to the practice, if the first appointment is a missed appointment (no-show, cancel, or less than 24-hour notice of a need to cancel), the privilege to schedule an appointment in advance will be lost and a child may be seen on a same-day only basis, as the schedule allows.

4b. Existing patients, after two missed appointments, the privilege to schedule an appointment in advance will be lost and a child may be seen on a same-day only basis, as the schedule allows.

5. **Late Patient Policy:** Panther Pediatric Dentistry will try to work a late patient into the schedule, if possible, and planned treatment may be modified based on time. However, if my child arrives more than 10 minutes late for the appointment, I understand that the appointment may be canceled and counted as a missed appointment. After two missed appointments, the privilege to schedule an appointment in advance will be lost and a child may be seen on a same-day only basis, as the schedule allows.

6. **Insurance Policy:** I understand that it is my responsibility to make sure all insurance information is accurate (including primary, secondary, and tertiary insurances) at all times and I will notify Kari A. Cunningham, DMD, LLC (dba: Panther Pediatric Dentistry and WE Smile) of any changes that may occur. Failure to provide accurate information could result in denied claims and payment will be expected to be paid in full by the parent/guardian at the office's standard rate described in the treatment plan. I agree to disclose all dental insurances for my child. If I fail to advise Kari A. Cunningham, DMD, LLC that my child has multiple dental insurance policies and an insurance claim is denied because the insurance company indicates that a primary dental insurance exists for the patient, I may be issued a statement for the unpaid services for the patient at 100% of the standard fees of the practice.

7. **Financial Responsibility:** I, parent/legal guardian, will be responsible for any amount due for services rendered by Kari A. Cunningham, DMD, LLC not otherwise payable by my traditional or state-funded insurance policy. This includes but is not limited to non-covered services, deductible, and coinsurance amount. I understand that payment is to be made at or before the time treatment is rendered. Money orders can be made payable to *Kari A. Cunningham, DMD, LLC* or *Panther Pediatric Dentistry*. Credit card payments can be made over the phone by calling the office at 216-938-8501.

8. **Authorization of Release of Information for Treatment, Payment or Operations:** I authorize Kari A. Cunningham, DMD, LLC (dba: Panther Pediatric Dentistry) to release any information about me or my child to my insurance or its agents to assist in determining my benefits and or benefits payable for related services performed on my child.

9. I, the parent/legal guardian, authorize Kari A. Cunningham, DMD, LLC (dba: Panther Pediatric Dentistry) to perform an examination, dental prophylaxis (cleaning), fluoride treatment, and take dental radiographs (x-rays) as needed to fully diagnose and provide a comprehensive treatment plan for my child.

Signature (Parent/Legal Guardian):_____ Date: _____

~ FOR OFFICE USE ONLY ~

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. That acknowledgement could not be obtained due to the following:

☐ Parent/legal guardian refused to sign ☐ Other:_____
☐ An emergency situation prevented signing
☐ Communication barriers prohibited obtaining signature Staff Initials:_____ Date:_____

WE Smile & Panther Pediatric Dentistry

Media Release and Consent to Dental Photographs Form

Patient Name: _____ Birthdate:_____
Last First MI

I, _____ (Parent/legal guardian), authorize the doctors and team members of Kari A. Cunningham, DMD, LLC (dba: Panther Pediatric Dentistry or WE Smile) to take photographs, and/or videos of my minor child's face, jaws, and teeth before, during and after treatment.

I consent to allow the photographs and/or videos to be used for the following:

- Dental Records (i.e. to aid in understanding the treatment plan or to assess oral hygiene progress);
- To submit to the insurance company as needed for clarification of procedures performed;
- Dental Education (including lectures, continuing education seminars, clinical demonstrations, and professional publications such as journals or books, etc.);
- Marketing material, including websites and printed materials, social media outlets, patient education, PosiTiVe (Panther Pediatric Dentistry's TV photo album of inspiration and motivation); and
- Dental Research

I further understand that if the photographs and/or videos are used, my child's name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Check here if you **DO NOT WANT** your child's full-face photo used for any of the above purposes ☐

Signature (Parent/Legal Guardian):_____ Date _____

WE Smile & Panther Pediatric Dentistry

Detailed Financial and Collections Policy (effective 4/8/2021)

The daily operation of Kari A. Cunningham, DMD, LLC (DBA: Panther Pediatric Dentistry and DBA: WE Smile) depends upon reimbursement from patients, and/or their insurance company for the costs incurred while providing dental care for children. For the children with insurances for which Dr. Kari A. Cunningham is a provider, the practice will do its best to provide the parent/guardian with an estimate of costs associated with treatment.

There are times when the recommendation of preventive or restorative care exceeds the limitations set forth by the policy of an insurance plan. We will do our best to capture that information in advance from the insurance company when we draft treatment plans based on the individual needs of the patient. However, the parent/guardian/guarantor is ultimately responsible for the costs not covered by the insurance company.

Any deductibles, copayments, and estimated patient payments are to be collected at the time services are rendered. As a courtesy, our office will file insurance claims for primary and secondary insurances ONLY. Individuals with a tertiary dental insurance plan will be handled on a case-by-case basis by our Office Coordinator.

Payments received by our office from the insurance company will be applied to the patient account. Any remaining balance on the account, will be billed to the parent/guardian/guarantor in the form of a statement that is due within two (2) weeks from the date the statement was sent. Statements will be sent monthly at intervals of 30, 60, and 90 days past due. Phone calls will be made by our office in an attempt to reach the responsible party and collect the debt after the due dates of each statement sent. In the event the balance has not been paid and the account is at least 120 days past due, Kari A. Cunningham, DMD, LLC will **add a $30 fee** prior to sending the outstanding account balance to the collection agency in an attempt to collect the debt. Accounts that are sent to the collection agency will be dismissed from the practice and only upon receipt of a signed "Release of Information" form will records be transferred to another provider or released to the parent/guardian.

Your prompt attention to notices from our office is key to our ability to continue to provide quality, comprehensive, and timely care to all of our patients. Your cooperation and adherence to this policy is greatly appreciated.

Signature (Parent/Legal Guardian):_____ Date _____

Panther Pediatric Dentistry

Authorization to Consent to Dental Treatment for a Minor Child

The undersigned, as the parent/legal guardian of

Patient Name: _____ Birthdate:_____
Last First MI

a minor child, understands that they must be present at the child's initial dental visit to Panther Pediatric Dentistry to complete and submit new patient paperwork, meet the Doctor to establish a doctor/patient/parent relationship, review health history and discuss the diagnosis and treatment plan of the minor child.

Completion of this form hereby authorizes

1. _____ _____
(Authorized Person's Name) (Relationship to Patient i.e. grandparent, step –parent, friend)

2. _____ _____
(Authorized Person's Name) (Relationship to Patient i.e. grandparent, step –parent, friend)

3. _____ _____
(Authorized Person's Name) (Relationship to Patient i.e. grandparent, step –parent, friend)

4. _____ _____
(Authorized Person's Name) (Relationship to Patient i.e. grandparent, step –parent, friend)

who is 18 years of age or older, to obtain and consent to any and all dental care and treatment required by such minor in the absence of the undersigned. He/she **must bring valid photo identification** to the appointment and is expected to adhere to all policies of Panther Pediatric Dentistry. My consent shall remain effective until this instrument is revoked by me in writing or until a new form is requested to be completed by Panther Pediatric Dentistry.

The completion of this form supersedes all previous authorization to consent dental treatment for a minor child forms (except in circumstances of joint custody forms).

_____ _____
Printed Name Relationship to Patient (i.e. parent, legal guardian)

_____ _____
Signature of Parent or Legal Guardian Date Signed

_____ _____
Signature of PPD Team Member/Witness Date Signed

☐ **By signing below, I waive my option to authorize other people to consent to dental treatment for my minor child.**

_____ _____
Signature of Parent or Legal Guardian Date Signed

PANTHER Pediatric Dentistry

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/2/2020, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities. At times dental students may shadow in our office as part of their training. We will ask you to complete a form giving permission if a student is present on your child's treatment day.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have

been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Privacy Official: Dr. Kari A. Cunningham
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