Dr. Ledenyi Welcomes You to Clayton Pediatric Dentistry!

We focus on prevention! Our goal is to create a pleasant dental experience for all and to teach your child oral habits that will help keep their smile healthy and beautiful for a lifetime! Please let us know of any special concerns you or your child may have. To ensure the experience is a good one and minimize wait time, we need your understanding of and cooperation. Please sign below to indicate understanding and agreement.

 It is *imperative* that you (as the legal parent/guardian) remain in the office throughout the entire dental appointment. We strongly believe the best care can only be provided when we work closely together. A legal parent/guardian must accompany your child to our dental appointments. Should there be unusual circumstances where you may not be able to come, please speak with us as soon as possible. Once a treatment plan is established, it *may* be possible for someone else to transport your child for a visit. There are specific procedures to allow this which must be taken care of before the appointment time.

 We coordinate care and share information according to HIPAA guidelines. Please make sure that you have read our Notice of Privacy Practices, posted in our waiting area and obtain a paper copy for your personal records if you would like one. You will be asked to sign a form saying you have read/received a copy (you may also decline to sign this form.)

 Have the following important documentation with you:

- Photo ID of the parent/legal guardian attending the appointment
- Insurance card for verification of your insurance
- Copies of any legal documents awarding custody, guardianship, adoption, custodial care or granting legal privileges authorizing you to make treatment decisions.

 Payment is expected at the time of service. It is your responsibility to be fully aware of the terms of your child's dental insurance. Any co-pay, balance due is the responsibility of the person bringing the child in for treatment. Be sure to review our financial policy. Please let us know if you have questions or concerns.

 As a courtesy, we may use phone calls or electronic communications . Should we leave/send a message, please respond so we may discuss important information with you. From time to time, policies or your child's situation may change. If your communication services have been disconnected or changed, please contact us with the new information.

 If you need to cancel an appointment, please give us 24 hour notice. If 24 hour notice is not given it will be considered a broken appointment. Two broken appointments within a year will inactivate your child's care *and their siblings*. Once this happens, they will need a new dental home. We may consider reactivating care under certain circumstances at the discretion of management. We have limited appointments available and want to help those waiting to be seen. Your call will help us help the children.

 Dr. Ledenyi is a Diplomate of the American Board of Pediatric Dentistry. We offer a conservative approach to progressive care using advanced technology in a supportive, child focused practice. As specialists, pediatric dentist's treatment plan differently than general dentists. New Patient appointments include answering your concerns, an exam, oral cancer screening, caries risk assessment, hygiene instructions, intra-oral pictures, nutritional counseling. If necessary, your child will have a cleaning, fluoride treatment, tobacco counseling and x-rays. If you decline procedures, you must notify us prior to the start of the procedure. Recommendations are made to answer concerns, tailored for your child.

 No dental treatment within a year will close your child's file and they will not be considered a current patient. Should this happen, please give us a call when you are ready to resume dental care for your child. We are glad to answer any questions that you may have about your child's dental care and the services we provide. We look forward to working with you on your child's behalf!

Legal parent/guardian name (print): _____

Legal parent/guardian:_____ Date:_____

Clayton Pediatric Dentistry Financial Policy

Thank you for choosing us as your child's dental home. **Your child's oral health is our main concern.** To avoid possible misunderstandings, we are providing you with our financial policy, which applies to all patients that you bring to CPD. Questions or concerns? Please ask.

Payment is due at the time the services are rendered. Cash, checks, and all major credit cards are accepted. An application for our patient financing companies, CareCredit and BeWell is available. We also offer our in-house discounted service plan - Smile Savers – for those without dental insurance.

Please initial below to show that you understand and agree to the following:

_____ Parents or guardians that accompany minor children are responsible for the charges incurred that day. Guarantors (persons who sign this agreement) are responsible for balances on the family account.

_____ All charges are your responsibility, whether your insurance company pays or not. Some services are not covered benefits. Your employer selects coverage, services and how much insurance will pay. Verify dental coverage prior to your appointments. We **estimate** your out-of-pocket cost for you, given the information we have at that time. Your insurance company determines what is paid when the claim is filed, which may change at any time and is not guaranteed. **Ultimately, you are responsible for any balances not paid by your insurance.**

_____ Know your plan benefits and limitations to avoid surprises. Your insurance plan is a contract between you, your employer and the insurance company, not us. We offer assistance navigating your insurance benefits, but cannot guarantee accuracy or results. For information on your plan benefits and limitations, please contact your insurance company and employers Human Resource department.

_____ We file the claim on your behalf. All insurance benefit payments will be assigned directly to CPD. You grant CPD permission to exchange information with your insurance company and their associates related to your child's appointment here and their dental condition. With benefit assignment, should payment still be sent to you, you will remit payment to us within 10 days. If benefit payments are not assigned, payment in full is required at the time of service.

_____ Accounts are reviewed monthly. Account balances older than 30 days may be subject to fees and collections. A 1.5% monthly finance charge may be added to your account on unpaid balances. If your account goes to collections, you may incur a 35% collection fee and may be dismissed from our practice. When unpaid balances or payment arrangements are not met, we may see your child on an emergency basis only, for a limited time.

_____ We understand that temporary financial problems may affect the timely payment of your balance and need you to tell us. We will gladly work with you as best we can. Our aim is to help your child be healthy. We want to continue our good relationship while we work through financial concerns together.

I have read, understand and agree to this financial policy.

_____ _____ _____

Guarantor Printed Name Guarantor Signature Date

_____ _____

Witness Date

Patient Information

Patient/Child: _____ DOB: _____

Patient Nickname/Preferred Name: _____ Age: _____

Gender:_____ SS#:_____

School:_____ County: _____

Home Address:_____

Different mailing address?_____

Mailing address: _____

Who referred you/**how did you hear about us**? _____

Emergency contacts, other than legal parents/guardians (For us to contact in case of emergencies, loss of contact only):

1) _____ Phone(s): _____

2) _____ Phone(s): _____

Care Providers

Pediatrician: _____ Phone: _____

Other physicians, dentists, therapists involved in your child's care:

Name : _____ Phone: _____

Name : _____ Phone: _____

Name : _____ Phone: _____

Legal parent/guardian Information: Birth parent and/or must have legal custody/guardianship

Parent 1: Circle: Mother/Father Step-Mother/Father Legal guardian Other:_____

Name: _____ DOB: _____ SS#: _____

Driver's License #: _____ State of Issue: _____

Address if different from child:_____

Works outside of the home: Yes No Employer: _____

Parent 2: Circle: Mother/Father Step-Mother/Father Legal guardian Other:_____

Name: _____ DOB: _____ SS#: _____

Driver's License #: _____ State of Issue: _____

Address if different from child :_____

Works outside of the home: Yes No Employer: _____

Primary Insurance Information

Dental : _____ Subscriber: _____

Medical: _____ Subscriber: _____

Secondary Insurance Information

Dental : _____ Subscriber: _____

Medical: _____ Subscriber: _____

Consent for Use of Images

I, _____, agree that Laszlo Ledenyi, DDS, PA/Clayton Pediatric Dentistry may use my/my child's images, renderings, words or pictures in educational and/or promotional materials. These materials may among others, include

- instructional/promotional pictures, video, training and educational materials
- internet/web sites
- practice brochures, t-shirts, displays.

I understand that

- I will not be compensated financially or in any other way for the use of my/ my child's likeness.
- My/my child's last name will not be used without my permission.
- Where possible, my/my child's identity will be obscured in these images.

By my signature below, I confirm that

- Dr. Laszlo Ledenyi, DDS or his representative has explained to me the way in which my/my child's image(s) will be used.
- I have had the opportunity to ask questions about this use.
- All my questions have been answered and
- I do authorize and consent to the use of my/ my child's image(s) in the way(s) indicated above.

Revoking consent must be in writing and applies from the date received forward.

_____ _____

Patient name Date

_____ _____

Signature of legal parent/guardian Relationship

Clayton Pediatric Dentistry
482 East Main Street Clayton, NC 27520-2529
www.claytonkidsdentist.com
Phone: (919) 553-3232
Fax: (919) 553-8186

Clayton Pediatric Dentistry

Acknowledgement of Receipt of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Legal parent/
guardian name (print):_____

Legal parent/
guardian signature:_____

Date:_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify)**:**

Consent to Use Electronic Communications

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with Clayton Pediatric Dentistry. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the doctor may impose on communications with parents/patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the doctor or the doctor's staff using the Services may or may not be encrypted. Despite this, I agree to communicate with Clayton Pediatric Dentistry using these Services with a full understanding of the risk.

I acknowledge that either I or Clayton Pediatric Dentistry may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice which will take effect upon receipt, excluding prior communications. Any questions I had have been answered.

Clayton Pediatric Dentistry has offered to communicate using these means of electronic communication ("the Services"). My preferences are indicated below by selecting/writing "yes" or "no":

(Yes/No) Email	(Yes/No) Website/Patient Portal	(Yes/No) Videoconferencing (including Skype®, FaceTime®)
(Yes/No) Text messaging (including instant messaging)		(Yes/No) *Social media (specify):
(Yes/No) Phone Messages may be left about **(please circle) appointments/dental/medical/accounts/insurance.**		

* Clayton Pediatric Dentistry will not use social media for health, account, finance, insurance information.

Except as indicated above for social media, specific description of patient information to be used or disclosed:

(Yes/No) Appointments	(Yes/No) Dental	(Yes/No) Medical	(Yes/No) Account	(Yes/No) Insurance

Patient name:	
Patient address:	
Legal parent/guardian home phone:	
Legal parent/guardian mobile phone:	
Legal parent/guardian email (if applicable):	
Other account information required to communicate via the Services (if applicable):	
Legal parent/guardian signature:	Date:
Witness signature:	Date:

Clayton Pediatric Dentistry
482 East Main Street
Clayton, NC 27520-2529

Office: 919.553.3232
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www. claytonkidsdentist.com

Appendix: Risks of Using Electronic Communications

Clayton Pediatric Dentistry (hereafter "CPD") will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to Use Electronic Communications). However, because of the risks outlined below, CPD cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of CPD or the parent/legal guardian.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications may be disclosed in accordance with a duty to report or a court order.
- Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

If the email or text is used as an e-communication tool, the following are additional risks:

- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

Conditions of using the Services

- While CPD will attempt to review and respond in a timely fashion to your electronic communication, CPD cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters.
- If your electronic communication requires or invites a response from CPD and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on CPD's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- CPD may forward electronic communications to staff and those involved in the delivery and administration of your care. CPD might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
- You and CPD will not use the Services to communicate sensitive medical information about matters specified below, unless "Yes" is indicated:

  (Yes/No) Sexually transmitted disease

  (Yes/No) AIDS/HIV

  (Yes/No) Mental health

  (Yes/No) Developmental disability

  (Yes/No) Substance abuse

  (Yes/No) Other (specify):

Appendix, cont'd

- You agree to inform CPD of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying CPD in writing.
- Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
- CPD is not responsible for information loss due to technical failures associated with your software or internet service provider.

Instructions for communication using the Services

To communicate using the Services, you must:

- Reasonably limit or avoid using an employer's or other third party's computer.
- Timely inform CPD of any changes in the legal parent/guardian's email address, mobile phone number, or other account information necessary to communicate via the Services.

If the Services include email, instant messaging and/or text messaging, the following applies:

- Include in the message's subject line an appropriate description of the nature of the communication (e.g. "prescription renewal"), and your full name in the body of the message.
- Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to CPD.
- Ensure that CPD is aware when you receive an electronic communication from CPD, such as by a reply message or allowing "read receipts" to be sent.
- Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to CPD.
- If you or your child require immediate assistance, or if your child's condition appears serious or rapidly worsens, you should not rely on the Services. Rather, you should call CPD's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.
- Other conditions of use in addition to those set out above: *(legal parent/guardian to initial)*

_____

I have reviewed, understand and accept the risks, conditions and instructions described in this Appendix:

Legal parent/guardian name (print): _____

Legal parent/guardian signature: _____

Date: _____