CHILDREN'S DENTAL HEALTH CENTER, P.L.C.

9006 E. 62ND STREET SOUTH, SUITE A · TULSA, OK 74133
(918) 249-0249 FAX (918) 249-1055

FINANCIAL COMMITMENT

I understand responsibility for payment for dental services provided in this office for my dependents is mine, due and payable at the time services are rendered unless other financial arrangements have been made with this office. In the event payments are not received by agreed upon dates, I understand that a 1 ½ % monthly finance charge (18% annual percentage rate) may be added to my account. I agree to pay the commission of the collection agency in the event my account must be turned to collections.

TREATMENT CONSENT

I understand that the information that I have been given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment.

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize the office of Dr. Randall Graham/Children's Dental Health Center to submit claims for payment for services to the health care service plan or insurance company named below, on my behalf and in my name, and assign such Provider the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any balances not satisfied by my insurance benefits, regardless of the basis for nonpayment by my insurance carrier. I authorize Dr. Graham's office to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the office of Dr. Randall Graham/Children's Dental Health Center to provide any health care provider, insurance company, health care service plan, self-insurers, or their representatives, all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed for further treatment, to review, investigate, or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union or entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. **The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.**

NOTICE OF PRIVACY POLICY

I have received a copy of Children's Dental Health Center's Notice of Privacy Policy, as required by HIPAA, effective April 15, 2003, and have reviewed this information in its entirety.

Patient: _____ Date: _____ _____

Legally Responsible Parent/Guardian (if applicable)

CONSENT FOR THE USE OF LOCAL ANESTHESIA, NITROUS OXIDE / OXYGEN, SEDATION OR GENERAL ANESTHESIA FOR DENTAL TREATMENT

I give my consent to the use of local anesthetics, sedative drugs, general anesthetic agents, or nitrous oxide/oxygen that the dentist may deem necessary or advisable so as to enable the providers of service to render dental treatment to the patient named below. Additionally, I give my consent to any other procedure deemed necessary or advisable as a corollary to the planned treatment for the patient named below.

I have been informed and understand that occasionally there are complications involved in the use of these types of drugs or anesthetic agents; including but not limited to: numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, stroke or heart attack. I further understand and accept that complications may require hospitalization and may even result in death.

The doctor has discussed with me, to my satisfaction, these complications. I acknowledge the receipt of and understand the preoperative and post-operative instructions. The treatment and sedation and/or anesthesia procedures have been explained to me, to my satisfaction; along with possible alternative methods and their advantages and disadvantages, risks, consequences and probable effectiveness of each as well as the prognosis if no treatment is provided. I understand that the use of restraints may be necessary during dental treatment with conscious sedation as a safety measure.

I acknowledge that prior to my execution of this consent, I have read this consent and understand, to my satisfaction, the procedure to be performed and accept the possible risks, and acknowledge that a copy of this consent form is available upon request.

Patient: _____ Date: _____ _____

Legally Responsible Parent/Guardian (if applicable)

Witness: _____ Date: _____

Thank you for filling out this form completely. It will enable us to render comprehensive care. If you have any questions at any time, please feel free to ask us. We are here to help you reach and maintain your maximum health potential.