kidSMILES
PEDIATRIC DENTAL CLINIC

NOTICE TO PATIENT/CONSENT FORM

KidSMILES Pediatric Dental Clinic strives to provide quality dental care to children but as a part-time clinic staffed by volunteers, there are limitations to the services we provide. Please read this document carefully and sign. IF YOU DO NOT UNDERSTAND ANY PORTION OF THIS DOCUMENT, ASK FOR ASSISTANCE TO CLARIFY THE INFORMATION.

KidSMILES Operations

- I understand that KidSMILES is only open part-time and cannot respond to emergency dental problems. Appointments are made on a first-come, first-served basis.
- I understand that I must fill out a patient form with a detailed description of all health issues, allergies and medications my child takes to ensure safe dental treatment. I am also aware that it is my responsibility to obtain the medications prescribed by the dentist and to give them as directed to complete my child's treatment. KidSMILES does not have medications on site and does not dispense controlled medications (narcotics).
- I understand that the clinic cannot guarantee that the same dentist will complete treatment at each appointment.
- I understand that at each appointment a record is made of the visit. It is the physical property of the clinic but the information belongs to me. I can request restrictions on certain uses of information, obtain a copy of the record, request that the information be shared with other health/dental care facilities or revoke my authorization of its use.
- I hereby acknowledge, and understand that by signing this voluntary care treatment consent I am giving the doctors and hygienists of KidSMILES Pediatric Dental Clinic permission to perform diagnosis and complete treatment of dental disease.
- I understand that the attending dentist may need to complete dental x-rays to diagnosis dental disease. I understand that no guarantees have been made to me as to the result of examination or treatment by this clinic. If treatment is deemed unsafe to complete at this facility, the proper referral for care will be made.
- I have received and read the HIPAA Notice of Privacy Practices.

Parent Initials____

KidSMILES Policies

- I understand that KidSMILES has a guideline that families whose children are treated at the dental clinic earn less than 250% of the Federal Poverty. I agree that our family meets that requirement according to the guidelines below:

2 household members = $39,325	5 household members = $69,775
3 household members = $49,475	6 household members = $79,925
4 household members = $59,625	7 household members = $90,075

  - Number of family members in household_____
  - Annual household income_____

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KidSMILES Policies (continued)

- Due to the high number of children who need affordable dental care, I understand that if I cannot bring my child to a scheduled appointment, I must give KidSMILES at least **24 hours notice.** Your child will then be rescheduled immediately.
- I understand that if I do not show up to a scheduled appointment a ***broken appointment*** will be recorded in my child's dental chart and ***my child will be placed at the end of the waiting list. If my child misses three appointments, we will no longer be able to receive services at the KidSMILES clinic.***
- I understand that if my child is more than 10 minutes late for an appointment, a broken appointment will be recorded. The KidSMILES staff will do its best to complete as much treatment as possible in the remaining appointment time. I also have the option of rescheduling the appointment.

Parent Initials____

Photo Consent and Release

- I give consent to the use of my words and story, photographs, video footage and/or audio clips by KidSMILES Pediatric Dental Clinic, and further consent to the reproduction, use and distribution of the photos, video footage, audio clips, proofs and negatives without compensations.
- I release KidSMILES, it's agents, volunteers, employees and assignees to and from any and all claims by reason of the use of said photos, video footage, audio clips, proofs, negatives and any and all reproductions and distributions thereof.

Parent Initials____

Name of Patient Receiving Care_____ Date_____

Name of Person Authorized to Give Treatment Consent_____

Signature of Person Authorized to Give Treatment Consent_____

Relationship to Patient_____