NEW PATIENT INTRODUCTION

THANK YOU for choosing our clinic for your child's dental care. As an office specializing in dental care for children, we offer a child-friendly atmosphere as well as child-appropriate treatment options, when it is necessary. We believe in treating your children conservatively, fast, easy, and fun!

You will notice we do some things differently for children than for adults, as they have different needs - both physically and emotionally. Part of what makes pediatric dentistry a specialty is being able to tailor treatment needs to the child's state of development, both physically and emotionally.

FIRST VISIT INFORMATION:

We recommend every child be seen **by their first birthday**. Starting early helps prevent the dental fears that many adults have and helps us diagnose problems when they are easier to take care of.

A legal guardian is required to accompany the child for their first exam.

This allows for several benefits:

1. We are excited about taking care of kids and want to share that enthusiasm with you.
2. We want to involve you with what we find, rather than have you take our word for it.
3. A lot of education is provided at the exam. If you are not present, much of the education gets missed.
4. With the knowledge you will receive from being present for the exam, you can take more control of your child's oral health at home.

INFANTS AND TODDLERS

Until two or three years old, the exam is usually done with the child on the parent's lap. It is normal to be shy and sometimes to cry even for simple examinations. This is normal behavior and in no way does it upset us, and you should not be embarrassed nor should you feel obligated to quiet the child (if they are crying, their mouth is open). We are a pediatric practice and we expect some noise from the young children, and hope that you will have patience when there are other children still getting comfortable with dental visits.

PRESCHOOL AGE AND OLDER

We use a technique called Tell-Show-Do. You will recognize this as we first talk about things in a child-friendly way. Then, when appropriate, we show them what we are going to do. Lastly, we move slowly in baby steps when we do any procedure. This prevents any big surprises that may frighten the child. Using this approach helps children be more comfortable and develops trust between the staff and your child.

CHILD FRIENDLY VOCABULARY

As a pediatric practice, we use child-friendly words to describe what we do. For example, we do not use four-letter words (such as hurt, pain, pull and shot). Please support us in making this experience fun by not going into detail with young children and allowing us to explain in ways that keep anxiety to a minimum. Some examples of the terminology we use:

We Do **NOT** Use:	We Do Use:
~~Shot~~	Squirt the Sleepy Juice
~~Drill~~	Tickle the sugar bugs
~~Pull the tooth~~	Do a Tooth Dance or Wiggle the tooth
~~Hurt~~	Feels weird/different

CLEANINGS

Parents and caregivers are often surprised by how fast a cleaning can be on children. Adult cleanings include removing mineral build-up between teeth and below the gum line. Children are not at risk of this same buildup until the pre-teen and teenage years. There are also not as many teeth to clean. All check-ups involve the following: exam, any necessary x-rays and fluoride, unless specifically requested with the dental assistant not to apply.

APPOINTMENT LENGTH

Children have shorter attention spans so we work as quickly as we can to keep children happy and content. THANK YOU for choosing Acorn Dentistry for Kids. We look forward to working together with you to maintain and improve the health of your child.

I have received and read the Acorn Dentistry for Kids Introduction

Child(ren) Name(s) _____

Legal Guardian Signature _____ Date _____

ADK - INT

ACCOUNT INFORMATION FORM

PHONE: 503.874.4560 **FAX**: 503.874.4562 **EMAIL**: INFO@ACORNDENTISTRYFORKIDS.COM **WEBSITE**: WWW.ACORNDENTISTRYFORKIDS.COM

TODAY'S DATE:

Please choose the clinic location you would like your child(ren) to be seen in:

☐ **Silverton**	☐ **Keizer**	☐ **Corvallis**	☐ **Hillsboro**	☐ **West Salem** (coming soon)
411 N. Water St. Silverton, OR 97381	4817 River Rd. N Keizer, OR 97303	1731 NW Kings Blvd Corvallis, OR 97330	434 S. 1st Ave. Suite 300 Hillsboro, OR 97123	1049 Edgewater St. NW Suite 100 Salem, OR 97304

HOW DID YOU HEAR ABOUT US? (CHECK THE APPROPRIATE BOXES AND GIVE US THE DETAILS)

☐	FRIEND or RELATIVE	If so, who can we thank?
☐	EXISTING PATIENT	If so, who can we thank?
☐	INSURANCE COMPANY	Name of Ins. Company
☐	MEDICAL/DENTAL REFERRAL	Name of referring Office?
☐	Advertisement	Where did you see our Ad?
☐	BILLBOARD	Location of Billboard
☐	SOCIAL MEDIA	(Facebook, Instagram, etc)
☐	OTHER	Please describe:

ACCOUNT INFORMATION (LEGAL GUARDIAN/PARENT #1)

Legal Guardian/Parent #1 **FIRST AND LAST NAME**		Legal Guardian #1 Relationship	
Legal Guardian #1 Birthdate		Legal Guardian #1 Cell Phone Number	
Legal Guardian #1 Email			
Legal Guardian #1 Mailing Address			

ACCOUNT INFORMATION (LEGAL GUARDIAN/PARENT #2)

Legal Guardian #2 Full Name		Legal Guardian #2 Relationship	
Legal Guardian #2 Birthdate		Legal Guardian #2 Cell Phone Number	
Legal Guardian #2 Email			
Legal Guardian #2 Mailing Address			

PRIMARY LANGUAGE SPOKEN AT HOME

_____ Check box if an interpreter is needed at your appts ☐

ADK - AIF

CONSENT FOR SERVICES AND FINANCIAL POLICY

PAYMENT/INSURANCE POLICY:

As a condition of treatment by this office, full payment is expected at the time of service unless prior financial arraignments are made. While we work with almost all insurance companies and offer an In-House Dental Savings Plan – ACORN PRIME, for those who do not have insurance coverage (Program information available upon request); the practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

We are pleased to offer the following payment options for your convenience: 1. Personal Credit/Debit Cards: We take Master Card, Visa, Discover, and American Express. 2. Personal Check. Patients will be charged $30.00 for any check returned for non-sufficient funds (NSF). 3. Cashier's Check. 4. Money Orders. 5. An additional financial option that is administered for us: Care Credit. (Please ask for additional information regarding this service). 6. If none of the above options work, we also offer generous in-house payment plans. A credit card authorization will need to be completed and kept on file for automatic monthly payments. The Payment Plan must be created prior to any treatment being performed. NOTE: Monthly billing statements are sent via email. Please list email below in the space provided.

*****PLEASE INITIAL HERE THAT YOU HAVE READ AND UNDERSTOOD THESE PAYMENT OPTIONS: _____. *****

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for, in full, at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy to our patients, this office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, we do not act as an agent of the insurance company. The insurance contract is between you, the patient, and the insurance company; therefore, the patient is responsible for the bill regardless of insurance coverage. By signing below, you confirm your understanding that any fee estimate for this dental care can only be extended for a period of 90 days from the date of the patient examination.

I hereby authorize payment directly to Acorn Dentistry for Kids of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment. I agree that I am fully responsible for all costs and the total payment of all procedures performed in this office; this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due to be paid in full within sixty (60) days, regardless of whether or not my insurance benefits have been received and that one and one-half percent (1.5%) per month interest (18% annually) will be charged on accounts 60 days from the treatment date. I agree to pay a $5 billing fee for each month my balance remains outstanding and statements are generated. I also understand that should credit be extended to me by this office, a credit check will be made, and I authorize release of all financial information.

MISSED APPOINTMENT POLICY:

We ask for at least a 24-hour notice if you are unable to keep a scheduled appointment. ***For missed or broken appointments with less than the required notice, a late fee may be assessed up to, but not more than, $50.00. We reserve the right to dismiss any client for failure to keep their scheduled appointments.***

PAPER STATEMENT FEE:

Acorn Dentistry for kids sends out statements via email. If you would like to receive a paper statement, there will be a $5.00 Paper Statement Fee added to your account. By receiving your statement electronically, we are collectively reducing waste and minimizing our environmental footprint.

MISSED SEDATION AND OPERATIVE APPOINTMENTS:

Due to the high demand for sedation appointments, we have implemented a Missed Surgical/Operative Appointment Policy to encourage patients to keep their scheduled appointments. If you cannot attend your scheduled appointment, you must call during office hours, a minimum of ***72 hours in advance***. If we do not have a 72-hour advance notice of cancellation, you will be charged a ***$200 non-refundable Surgical/Operative Appointment Fee.***

We are here to assist you in any way possible. Please make your questions and concerns known to our helpful staff.

Signature: **Date:**

_____

By signing you acknowledge and agree that the information above is correct to the best of your knowledge.

Email:_____

Mailing Address: Acorn Dentistry for Kids; P.O. Box 158, Silverton, OR 97381
Ph# 503-874-4560 Fax# 503-874-4562 Email: billing@acorndentistryforkids.com

ACORN DENTISTRY FOR KIDS
NO-SHOW, LATE AND CANCELLATION POLICY

DESCRIPTION

"No Show" shall mean any patient who fails to arrive for a scheduled appointment.

"Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment.

"Late Arrival" shall mean any patient who arrives at the clinic 5 minutes after the expected arrival time for the scheduled appointment.

POLICY

It is the policy of the practice to monitor and manage appointment no-shows, cancellations and late arrivals. ***We reserve the right to dismiss any patient/family for failure to keep their scheduled appointments.***

One of Acorn Dentistry for Kids' goals is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, families are required to call or leave a message at least 24 hours before their appointment time, or 72 hours before their treatment appointments.

This notification allows Acorn Dentistry for Kids to better utilize appointments for other patients in need of urgent dental care.

Fees may be assessed.

Exams: Up to $50.00.
Sedation/Operative/Surgery/Anesthesia: Up to $200.00
Due to the high demand for sedation appointments, we have implemented a Missed Surgical/Operative Appointment Policy to encourage patients to keep their scheduled appointments. If you cannot attend your scheduled appointment, you must call during office hours, a minimum of ***72 hours in advance***.
If we do not have a 72-hour advance notice of cancellation, you will be charged a ***$200 non-refundable Surgical/Operative Appointment Fee.***

PROCEDURE

A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. A copy of this signed notification can be given to patients at their request.

Established patients:

a. Appointment must be cancelled at least 24 hours prior to the scheduled appointment time.
b. In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will need to be rescheduled for a future clinic visit.
c. In the event a patient has incurred any documented "no shows, cancellations less than 24 hours or late arrivals - the patient/family may be subject to dismissal from Acorn Dentistry for Kids clinics. The patient's chart is reviewed, and dismissals are determined by dentist only. In the event your child/family is dismissed from the clinic we will continue to provide basic emergency care for 30days, while you seek new dental care elsewhere.

New patients:

a. Appointment must be cancelled at least 24 hours prior to scheduled appointment time.
b. In the event a patient has incurred any documented "no shows, cancellations less than 24 hours or late arrivals - the patient/family may be subject to dismissal from Acorn Dentistry for Kids clinics. The patient's chart is reviewed, and dismissals are determined by dentist only.

Parent/Legal Guardian Printed Name_____

Parent/Legal Guardian Signature_____ Date_____

HIPAA CONSENT FORM

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you, Acorn Dentistry for Kids, to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)
- The day-to-day healthcare operations of Acorn Dentistry for Kids dental practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that Acorn Dentistry for Kids reserves the right to change the terms of this notice from time to time and that I may contact them to obtain the current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, and that you are then bound to comply to this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

Signature of Parent/Legal Guardian _____ **Date:** _____

Printed Name of Parent/Legal Guardian: _____

Relationship to Child(ren) _____

Printed Name of child(ren)_____

To view a full copy of the HIPAA Notice of Privacy Practices or would like a copy printed for you, please see our Smile Squad at the front desk.

411 N Water St
Silverton, OR 97381

4817 River Rd. N
Keizer, OR 97303

1731 NW Kings Blvd
Corvallis, OR 97330

434 S. 1st Ave
Hillsboro, OR 97123

Ph: 503.874.4560
Fax: 503.874.4562
info@acorndentistryforkids.com
www.acorndentistryforkids.com

ACCOMPANY AUTHORIZATION

Should a parent or guardian not be able to accompany their child to an appointment, this authorization form outlines consent by a legal guardian for another person to accompany their child(ren) to an appointment at Acorn Dentistry for Kids.

This authorization *does not* permit them to consent to treatment of the child on behalf of the legal guardian. Only legal guardians can consent to treatment and provide updates to the child's health history.

Acorn Dentistry for Kids will determine the type of appointments in which a legal guardian is required to be at their child's appointment.

Child(ren)'s First and Last Name(s)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Authorized Adults

1. _____ Relationship to child _____

2. _____ Relationship to child _____

3. _____ Relationship to child _____

Please note: The authorized adults above will be required to provide picture ID at each appointment.

By signing this form, I agree that I am the parent/legal guardian of the child(ren) listed above and I authorize the following people to bring my child(ren) to scheduled appointments.

_____

Printed Name of Parent/Legal Guardian

_____ _____

Relationship to child Date

_____

Parent/Legal Guardian Signature

At your child(ren)'s six month exam, an updated medical/dental form will be required; therefore arrangements to have a parent/legal guardian complete the updated medical/dental update form will have to be made prior to the appointment.

PHOTO RELEASE CONSENT

Here at Acorn Dentistry for Kids, we make every effort possible to make our patients feel special and celebrated. We love to share photos and videos of our patients on our social media, website and other office related materials - so our friends and family can see just how much fun a visit to the dentist can be!

Please check one of the following boxes and sign below.

☐ **I AGREE** and hereby grant full permission to Acorn Dentistry for Kids to use either myself or my child(ren)'s name(s) and pictures in any publication or advertising materials (printed or electronic) and social media. This consent serves to waive all rights of privacy or compensation which I may have in connections with the use of my photograph and/or my child's photograph or first name. Be sure to follow our social media sites for a chance to see your child(ren)'s smile!

☐ **I DO NOT AGREE** to have mine or my child(ren)'s name(s) or photograph used for public viewing.

Date _____

Child(ren)'s Full Name _____

_____

_____

Parent/Legal Guardian's Name _____

Parent/Legal Guardian's Signature _____

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Silverton, OR 97381

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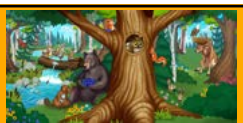

CLICK HERE to submit completed forms to Acorn Dentistry for Kids