EATON PEDIATRIC DENTISTRY, P.C.
JONATHAN EATON, DDS, MS
3744-A LAVISTA ROAD
DECATUR, GEORGIA 30033

PATIENT NAME: _____

I attest that the information I have given today is correct to the best of my knowledge. A photocopy or facsimile copy of this form may be used as an original. I understand that it is my responsibility to inform this office of any changes in my child's medical status. I give my consent to needed dental services which may include topical fluoride application, necessary x-rays, clinical photographs, local anesthetic, nitrous oxide analgesia (laughing gas) and the use of proper and acceptable methods to complete same. I understand that video monitoring is conducted in treatment areas, business areas, and play areas. **I ACCEPT RESPONSIBILITY FOR PAYMENT FOR SERVICES RENDERED FOR MY CHILD.**

X_____ _____
Signature of Parent or Legal Guardian Date

I understand that fees for all dental services furnished by this office are charged directly to the patient's parent and that the patient's parent is personally responsible for the payment for all dental services. As a courtesy, this office may help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. I understand that insurance may not cover 100% of the cost of dental services and that in some cases insurance may provide little or no coverage for certain necessary services. **I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT FOR SERVICES RENDERED FOR MY CHILD REGARDLESS OF THE LIMITATIONS OF ANY INSURANCE BENEFITS. ANY INSURANCE BALANCE REMAINING OVER 30 DAYS IS DUE AND PAYABLE IN FULL BY THE PARENT.** I understand that if my account for any reason becomes overdue then the account may be turned over to an outside collection agency. I understand that I will be held responsible for all additional fees required to collect on this account.

X_____ _____
Signature of Parent or Legal Guardian Date

I hereby authorize assignment directly to Eaton Pediatric Dentistry, P.C. and Jonathan J. Eaton, DDS, MS of the insurance benefits otherwise payable to me and authorize the release of information regarding treatment and billing to the insurance company and their agents.

X_____ _____
Signature of Parent or Legal Guardian Date

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, to obtain payment from third-party payers, and to conduct normal healthcare operations.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X_____ _____
Signature of Parent or Legal Guardian Date