Kidsworld Pediatric Dentistry

## Consent for the Collection and Use of Medical Information

Here at Kidsworld Pediatric Dentistry, we understand the importance of maintaining and protecting the privacy of your child's personal information. We are committed to collecting, using, and disclosing your child's personal information responsibly. All staff members who come in contact with your child's personal information are aware of the sensitive nature of the information that you have disclosed to us. Our privacy protocols comply with "the personal information protection and electronic documents act" (PIPEDA), the standards of our regulatory body (RCDSO), and the law.

I, ____________________________________________________________, hereby acknowledge that I have
**(Parent/Guardian's Name)**
reviewed the above information and understand that Kidsworld Pediatric Dentistry will only collect and use personal information about ________________________________________________as necessary in order to
**(Child's Name)**
provide me with the highest quality of oral care. I, therefore, agree that Dr. Priya Kothari can collect and use my child's personal information as outlined above.

________________________________ ________________ ______________________

**Signature of Parent/Guardian** **Date** **Signature of Witness**

## Financial Policy

We're delighted you've chosen us to provide care for your child. Each child has unique oral health needs. As such, your child's treatment recommendations will be based on a thorough exam and diagnosis. As a courtesy, we will gladly submit the treatment directly to the insurance company. Please provide up-to-date verification information. The following policies are in effect in the interest of fairness to all the children that need our care:

- For all cases, payment is made directly to our office and is expected at the time services are rendered.
- For Sedation cases a **$300.00, non-refundable, sedation fee is required on treatment day.**
- For General Anesthesia (GA) cases: A nonrefundable deposit of $500 is required in order to secure an appointment date for your child's surgery. This deposit, while nonrefundable, will be applied toward the cost of the treatment. A minimum of two weeks before the appointment, 50% of the estimated cost of treatment must be paid. The remaining balance must be paid on the day of surgery.

We are pleased to accept Cash or Credit Card (MasterCard/Visa). A receipt will be issued to you once payment has been made. You are responsible for sending the receipt and claim forms to your insurance company. Your insurance company will reimburse you directly, according to the terms of your contract. Payment for services rendered is your responsibility, and not that of any insurance company.

Your child's appointment time has been especially reserved. We require **2 business days** notice to change appointments, otherwise we may charge for lost time.

I have read and agree to follow the policies, and understand that **the parent or legal guardian who accompanies this child is responsible for all fees.**

**Relationship to child** ☐Parent ☐Guardian ☐Other ______________

____________________________ __________________ ______________________

**Name of Parent/Guardian** **Signature** **Date**