Kidzania Pediatric Dentistry
Dentistry for Children and Teenagers
3851 SW Green Oaks Blvd #123
Arlington, TX. 76017
817-483-2445

Office Policies

Accompanying your child

We ask that you allow your child to accompany our staff through the dental experience. Children aged 3 and up will go back to see the Dentist by themselves with our trained staff. Children aged 2 and under will be allowed to come back with a parent or legal guardian. We ask that the parents or the legal guardian accompany their child(ren) to the appointment.

Finances

Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan, which fits your schedule and budget. We accept cash, Mastercard, Visa and Discover.

Appointment Scheduling

Our office will attempt to schedule appointments at your convenience and when time is available. Preschool children (1-6 years) should be seen in the morning because that is when they are fresher and we can work more slowly with the child for their comfort. Dental appointments are an excused absence and we will provide your child with a school note. Missing school can be kept to a minimum when regular dental care is in place.

By reading and signing this form you agree to adhere to these office policies. If you have any questions or concerns regarding the treatment of your child, our office procedures, finance or anything else, please feel free to ask.

_____ _____
Parents Signature Date

HIPAA (Health Insurance Portability Accountability Act)

Notice of Privacy Practices
1. To Provide Treatment — We will use your health information you provide within our office to give the best dental care as possible. This may include sharing your information with referring dentists, physicians, pharmacies, clinical and dental laboratories or other health care personnel rendering treatment.
2. To Obtain Payment — A written invoice stating dental treatment performed will be sent to your insurance company and provided to you as well. This will include all services rendered in order to collect payment.
3. Abuse or Neglect — Government authorities will be notified if we believe a patient is the victim of abuse, domestic violence or neglect. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically or authorized by law or with the patient's agreement.
4. Friends, Family or Caregiver's — We will share your information with only those friends, family, or caregiver's when informed by you, the patient. This includes medications, treatment needed/performed and payment history. Written permission will be needed before disclosing any information.
5. Communication and Appointments — It has always been our courtesy to remind patients of upcoming appointments. This has included post cards/confirmation calls. By marking the appropriate line, you will let us know if you wish to continue to receive reminders or not.

_____ Yes, I do wish to continue to receive postcard/confirmation calls
_____ No, I would prefer not to receive postcards/confirmation calls
Thank you for taking the time to review the latest HIPAA regulations. Please sign the bottom of this form so we may keep it part of your record. If you would like a copy of this, please let us know.

_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN Date