9221 Forest Hill Ave • Richmond • VA 23235 2929 Polo Parkway • Midlothian • VA 23113

We appreciate your confidence in selecting our office for your orthodontic treatment. We want you to be fully informed and feel free to ask questions at any time. Please understand that an important part of your treatment includes making dental arch models, x-rays, and photographs for your records, some of which may be taken several times during the course of treatment.

Consent to take X-Rays:
The standard of care in our office includes the use of dental radiographs (x-rays). X-rays are helpful in screening both upper and lower jaws and help diagnose the following:

1. Missing or impacted teeth
2. Orthodontic and orthognathic considerations
3. Bone loss (periodontal disease)
4. Defects and malignancies of the bones and jaw
5. Health of teeth, restorations, and dental prosthetics
6. Abscesses (infections) within the bone associated with teeth or gums.

X-rays are necessary to provide the level of diagnosis and care we strive for. At the time of your appointment our staff will notify you if you are due to have x-rays taken.

I do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time and I wish to have an x-ray examination performed. If you have questions or concerns, please feel free to ask any of our staff members. We value you as a patient and take pride in providing you with optimum dental care.

_____ _____ _____
Patient/Parent/Responsible Party Signature Relationship to Patient Date

Refusal of X-Rays:
I have read and understand the above radiograph policy. At this time, I am choosing to refuse the recommended x-rays. I understand that in so choosing, my dental/oral health conditions cannot be completely evaluated and diagnosed. I also understand there may be undiagnosed conditions that cannot be seen without an x-ray and may compromise orthodontic treatment resulting in an undesirable treatment outcome. Understanding this, I do not hold Dr. Richard Byrd & Associates or any staff member liable or accountable for problems that may arise or go undetected as a result of this decision.

_____ _____ _____
Patient/Parent/Responsible Party Signature Relationship to Patient Date

Initial_____

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Privacy Policy **Consent Form Page 2**

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

• Treatment (including my direct or indirect treatment by other healthcare providers involved in my treatment)

• Obtaining payment from third party payers (e.g. my insurance company)

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 you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most 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 additional procedures, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

All children under 18 must be accompanied by a parent or legal guardian for their appointments. This includes new patient appointments (consults) and orthodontic appointments. It is our office policy that a parent or legal guardian be present in the building. Parents/legal guardians should stay in the waiting room until the orthodontic appointment is complete, at which time the technician will review the completed appointment with the parent/guardian. If your child is brought by any other person other than the ones listed below they will be asked to reschedule. Furthermore, due to HIPPA regulations (confidentiality laws), we cannot discuss treatment with anyone other than a parent or legal guardian unless permission to discuss protected health information listed on the patient consent form has been filled out. Once a patient turns 18 years of age, we are no longer obligated to discuss treatment or account information with anyone but the patient, unless a consent form is signed by the patient.

<u>Permission to Discuss Protected Health Information</u>

I hereby give my permission to the office of Richard L. Byrd, DDS; PC to discuss my/my child's protected health information with the following individuals:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

_____ _____ _____
Patient/Parent/Responsible Party Signature Relationship to Patient Date

Initial_____

Dr. Richard Byrd & Associates
ORTHODONTICS & PEDIATRIC DENTISTRY

9221 Forest Hill Ave • Richmond • VA 23235 2929 Polo Parkway • Midlothian • VA 23113

We may need to contact you regarding your dental care. This is to acknowledge that you authorize Richard L. Byrd, DDS, PC to (check all that apply):

- ☐ Leave a detailed voice message on of the following number(s)_____
- ☐ Call my workplace phone number and leave a detailed voice message
- ☐ Call my workplace phone number and speak only to me
- ☐ Transmit and receive messages through email
- ☐ Send text messages to the following number(s)_____
- ☐ None of the above

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

Signed this _____ day of _____, 20_____.

_____
Print Patient Name

_____
Signature of Responsible Party

_____
Relationship to Patient

_____
Address

_____
City, State, Zip

(_____)_____ (_____)_____
Home Phone Work Phone

(_____)_____ _____
Cell Phone Email Address

Are you requesting a copy of our Notice of Privacy Practices? ☐ Yes ☐ No

_____ _____
Signature of Staff Member Date

Initial_____