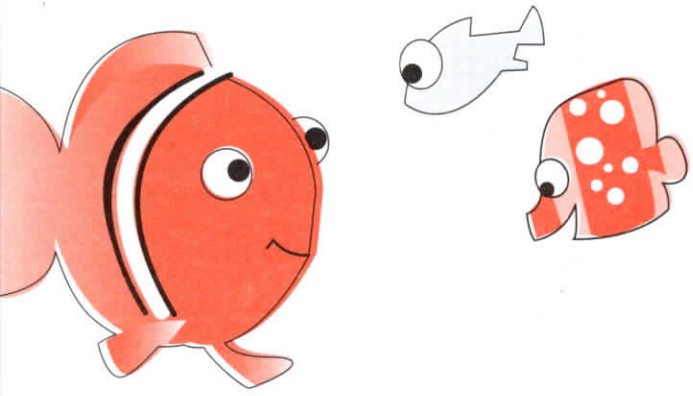

alamance pediatric dentistry

M. Todd Grooms, DDS, MS
& Associates

Diplomate of the American Board of Pediatric Dentistry

306-c Alamance Road Burlington, NC 27215
T 336-227-5444 F 336-227-0029

We are pleased to welcome your family to our practice.

The first visit to the dentist may be the most important in your child's life. It's an experience that will help determine life-long health attitudes. That's why we go slowly, and take all the time your child needs to feel comfortable and encourage curiosity.

We schedule younger children and first appointments early in the day, when children are more rested. You can help make the first visit pleasant by reinforcing our role as the doctor who helps keep teeth healthy. We welcome your attendance during your child's visit. However, if you think that your child will be more cooperative without you being present, or if you are encouraging independence, it is fine for you to wait in the reception area. We'll explain everything to your child that we are doing so that there are no surprises. We want to build a relationship of trust and friendship with you and your child. Children under the age of 18 must be accompanied by a parent or legal guardian for the entire appointment.

As for the dental exam, we'll look carefully at teeth and gums. In addition, we will assess your child's dental growth, the development of the bite and how the jaws are aligned. We may take x-rays if we need a closer look at the teeth or the jaws.

When we welcome a new patient to the practice, we also welcome any questions you as a parent may have about office policies, insurance, and fees. We work very hard to control the cost of dental care. It's part of our philosophy that quality care should be available to everyone regardless of financial status. Should dental treatment be required, we will explain our fees to you. Insurance makes life easier. We file insurance claims electronically and are happy to answer any questions that arise. Each policy is different, but in general, insurance usually covers 100% of preventive care, 80% of basic care, and 50% of major services. We estimate the portion of services not covered by your insurance plan and collect only this amount and applicable deductible on the date of service.

When payment from your insurance company is received and applied to your account, any balance due will be billed to you, and any overpayment is refunded to you upon your request.

For our patients without insurance, we ask that you pay for services on the day they are completed. We accept cash, checks, debit cards, VISA, MasterCard, Discover and CareCredit. CareCredit is a no interest or low interest financing plan; we have applications in the office. The way we see it, there's always a way to get the help you need.

We will attempt to contact you to remind you about your child's dental appointments. If you are unable to keep your child's dental appointments, kindly give our office 24 hours notice so that we may reschedule the appointment and enable another child to be seen for dental care. In certain cases, there is a broken appointment fee assessed if 24 hours notice is not provided. If two appointments are missed without adequate notification of cancellation, this will result in termination of care for your child.

Enclosed please find a patient registration form, a medical/dental history form, behavior questionnaire, HIPAA Acknowledgement form, Notice of Privacy Practices, and Release of Clinical Information Form. *Please complete these forms and return them to our office prior to their appointments.*

Please let us know if you have any questions. We look forward to meeting you and your family!

Very truly yours,

Michael Todd Grooms DDS MS
M. Todd Grooms, DDS, MS
Diplomate of the American Board of Pediatric Dentistry

ALAMANCE PEDIATRIC DENTISTRY
HISTORY AND CONSENT FOR TREATMENT

Patient Name: _____ Sex: M F

Patient Date of Birth: _____/_____/_____

Address: _____ Phone: _____

Medical History

Name of Child's Pediatrician: _____
Name of Practice: _____ Phone Number: _____

Has your child been under the care of a physician during the last year, other than for routine care? Yes No
If yes, please explain: _____

Is your child currently taking any medications: Yes No
If yes, please list all medications:
_____
_____

Has your child ever been hospitalized? Yes No Reason: _____

Has your child ever had surgery? Yes No Reason: _____

Is your child allergic to penicillin or any other drugs? Yes No Please list: _____

Does your child have any other allergies? Yes No Please list: _____

Does your child have good physical coordination? Yes No

Is your child up-to-date on all recommended vaccinations? Yes No

Does your child have any emotional problems or issues? Yes No
If yes, please explain: _____

DOES YOUR CHILD HAVE ANY HISTORY WITH THE FOLLOWING:

Please mark if applicable

o ADHD/ADD	o Breathing Problem	o GI Reflux	o Mononucleosis
o Anemia	o Cerebral Palsy	o HIV/AIDS	o Pregnancy
o Arthritis	o Chronic Sinus	o Hearing Issue	o Rheumatic Fever
o Asthma	o Convulsions	o Heart Murmur/Issue	o Thyroid Disease
o Autism	o Diabetes	o Kidney Disease	o Tuberculosis
o Bladder	o Down Syndrome	o Liver/Hepatitis	o
o Blood Disease	o Epilepsy	o Malignancies	o

Summary (for office use only)

_____
_____
_____

Dental History

What is your main dental concern? _____

Is this your child's first visit to a dentist? Yes No

Who was the last dentist? _____ Date of last teeth cleaning? ____/____/____

Has your child complained about dental problems? Yes No
If yes, please explain:_____
Has your child had any unhappy dental experiences or nervousness? Yes No

Has your child had any injuries to the mouth, teeth or head? Yes No
If yes, please explain:_____

Does your child have any mouth habits (such as thumb sucking, pacifier, nail biting, bottle, etc.)? Yes No
If yes, please explain:_____

Has your child lost any teeth (naturally and/or by extraction)? Yes No
If yes, please explain:_____

Does your child brush his/her teeth twice daily?	Yes	No	Sometimes
Do you help your child brush and floss	Yes	No	Sometimes
Is dental floss used to help clean between teeth?	Yes	No	Sometimes
Is fluoride taken in any form?	Yes	No	Please explain:_____
Do you have city water or well water?	City	Well	

How did you hear about Alamance Pediatric Dentistry?_____

Summary (for office use only)

_____

_____

Permission for Treatment Upon a Minor Child

Patient's Name:_____ Age:_____

I, being the parent or guardian of the above minor patient, do hereby authorize and request the performance of dental services for this patient; and further, the performance of any/all dental procedures deemed necessary by the dentist during the performance of any dental treatment. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made concerning the results of the treatment the patient will receive.
I also authorize the administration of anesthetics or analgesics, which may be deemed advisable by the doctor, with my knowledge.
Furthermore, I will be responsible for any financial obligations incurred for this child's dental treatment. I also understand that payment for treatment rendered is expected at the end of each appointment.

Parent/Guardian Signature: _____ Date: ____/____/____

Printed Name:_____

ALAMANCE PEDIATRIC DENTISTRY
BEHAVIOR QUESTIONNAIRE

Name of Patient_____

How does your child behave for shots?

1) Shots do not bother my child
2) My child cries a little for a shot and then calms down
3) After a shot, my child is unable to calm down
4) My child has to be restrained by 2 or more people to receive a shot

Does your child have a gag reflex when things get near or in his/her mouth?

1) Yes
2) No

How does your child behave for new experiences?

1) My child is calm and likes new experiences
2) My child is hesitant about new experiences
3) My child is frightened by new experiences

What is the primary way in which your child learns new things?

1) My child watches an experience and learns that way
2) My child needs to hear about an experience to learn about it
3) My child needs to touch or feel things associated with the experience to learn about it

How much does your child weigh? _____ lbs.

Signature_____**Date**_____

Printed Name_____

Version 10/21/20

ALAMANCE PEDIATRIC DENTISTRY

AUTHORIZATION TO RELEASE HEALTH INFORMATION

This form allows Alamance Pediatric Dentistry to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name:

_____

(Last) (First) (Middle Initial)

Date of Birth: _____ **Main Contact Number:** _____

mm/dd/yyyy ☐Home ☐Cell* ☐Work

Mailing Address: _____

(Street)

_____

(City) (State) (Zip)

COMMUNICATING WITH YOU

PHONE

☐ Main Contact Number Above

☐ Other: _____

☐ Home ☐ Cell ☐ Work

DETAILED MESSAGES PERMITTED

☐ text (SMS)* ☐ voicemail ☐ None

☐ text (SMS)* ☐ voicemail ☐ None

EMAIL*

☐ _____

☐ All information from this practice ☐ Data breach notifications

☐ Appointment information only ☐ Billing Insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

LIST NAMES AND PHONE NUMBERS

_____

_____

_____

_____

YOUR PHOTOS & MULTIMEDIA

Photos/images may be used/posted:

☐ Photo of patient received by patient or legal guardian
☐ Photo taken by staff (e.g., pre/post procedure)
☐ Other

☐ May be posted in office
☐ May be posted on Website
☐ Other

* I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

PATIENT RIGHT & SIGNATURE

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cased where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____

Patient/Personal Representative **Date:** **mm/dd/yyyy**

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____
mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____
mm/dd/yyyy

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes:_____

_____

_____

ALAMANCE PEDIATRIC DENTISTRY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name of Patient_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

_____
Printed Name

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- o An emergency existed & a signature was not possible at the time.
- o The individual refused to sign.
- o A copy was mailed with a request for a signature by return mail.
- o Unable to communicate with the patient for the following reason:

_____

Other: _____

_____

Prepared By _____

Signature _____

Printed Name _____

Date _____

Version 10/21/20

Alamance Pediatric Dentistry Missed Appointment Agreement

We value our patients and need your cooperation with keeping appointments so that we can provide the best care for your child. Missing or cancelling an appointment at the last minute means we are unable to give this appointment to another patient who needs care.

Our policy requires:

- Compliance: Patients are only allowed **ONE** broken/failed appointment during their time at Alamance Pediatric Dentistry. After the **SECOND** broken appointment, you will be dismissed. _____ **Initials**

- Appointment confirmation: You must confirm your appointment within 24 to 48 hours before your scheduled time. If your appointment is not confirmed, the appointment may be given to another patient. This will be considered a broken appointment.
_____ **Initials**

- Timely Cancellations: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. We understand circumstances arise and this is not always the case.
_____ **Initials**

- On Time Arrivals: If you are more than 15 minutes late to your appointment, we may give your appointment to another patient. This will be considered a broken appointment.
_____ **Initials**

We value all of the patients at Alamance Pediatric Dentistry. Your help in keeping your appointments enables us to provide better and timelier care for all of our patients.

_____ _____

Patient or Parents/Guardian Signature **Date**

_____

Printed Name

2022

ALAMANCE PEDIATRIC DENTISTRY
M. TODD GROOMS DDS MS
FINANCIAL POLICIES AND YOUR DENTAL INSURANCE

We are committed to providing your child with the best possible dental care. If you have dental insurance, we want you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policies. Please be sure to read this form in its entirety and sign at the bottom.

We encourage our patients to be familiar with the cost of their child's dental treatment. A treatment plan will be provided to you before you consent to operative or restorative treatment. If you would like an estimate for routine preventative treatment one will be made available to you.

We will be happy to file your dental insurance both primary and secondary if applicable for you if the following conditions are met:
1. You must provide an up-to-date dental insurance card that we can use to verify your child's insurance before the treatment is completed.
2. Your child's insurance must be active on the date that the service is done. This policy is true for private insurance and state funded plans. If we are unable to verify your child's insurance you will be given the choice to either reschedule the appointment or pay all fees out of pocket.

Filing dental insurance is a courtesy that we provide for our patients. The relationship for your insurance is between you and your insurance company. We are not a third party involved in that relationship. Any and all non- covered services are the responsibility of the consenting parent/ guardian. All deductibles and non-covered services are to be paid at the time service is rendered. A pre-determination will be sent to your insurance company ahead of restorative or operative treatment and a copy will be mailed to you. All denied dental claims will be closed and an invoice and a copy of the denied explanation of benefits sent to you. We cannot call your insurance company to inquire about denied claims. All monies due and not paid within 30 days of the date of service will accrue a service charge monthly of 1.5%.

A note to divorced parents: The parent who brings the patient to our office for treatment will be responsible for our professional fees unless specific alternate arrangements are made in advance.

A 25.00 fee will be added for all returned checks.

Kindly give 24 hour notice for appointment cancellations to avoid a cancellation fee of 25.00.

I have read and agree to the Financial Policy stated above that applies to me.

_____
Child/Children Name

_____
Signed (Responsible Party) Date

_____
Printed Name

ALAMANCE PEDIATRIC DENTISTRY

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer.

Denise Hammond

Effective Date: 10/28/25 (336)227-5444 Revised: 10/28/2025

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlines in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website:

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualifications of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other healthcare providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- <u>If required by law:</u> The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- <u>Public health activities:</u> The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- <u>Health oversight agencies:</u> We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care

system, government benefit programs, other government regulatory programs and civil rights law.

- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for the national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law, which is necessary for your health or the health and safety of other individuals.
- Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatments.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

<u>All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.</u>

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based in the direction provided in the authorization, no further use or disclosure will occur.

<u>Your Privacy Rights</u>

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

> You may request for this practice not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.
>
> There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

> We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

> You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

> This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact.

Denise Hammond : Hippa Officer – (336) 227-5444

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective 10/28/25