

Financial Responsibility

All fees for treatment are paid at the time the treatment is provided. A written estimate of treatment cost will be provided prior to provision of treatment. Payment methods include cash, check, credit card, and a no-interest payment program (CareCredit). A 5% discount is offered for all payments by cash or check. Returned checks will be assessed a \$50 fee.

For most dental insurance companies, we will file the dental insurance claims for you. In some cases, we will accept payment directly from your dental insurance company. However, dental insurance is a contract between you and your insurance company, and in most cases your dental insurance company will not pay for the entire cost of treatment. Fees not covered by your dental insurance may include deductibles, co-payments or certain procedures not covered by your dental insurance company. Therefore, we will estimate the benefits of your dental insurance before each treatment and will collect the estimated portion which your insurance company is not expected to pay. We are not responsible for how your dental insurance company processes its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment; we at no time guarantee what your insurance will or will not do with each claim. Some dental insurance companies will not reimburse our office, but will pay dental insurance benefits to you. In this instance, we will file your dental insurance claim for you, and you will be responsible for full payment when treatment is provided.

If your dental insurance company has not provided payment within 30 days after submission of a dental insurance claim, we will notify you in writing and allow you 14 days to complete payment.

A monthly finance charge of 1.5% (minimum finance charge is \$5) may be applied to account balances which remain unpaid either 30 days after provision of treatment or after the 14-day period described for dental insurance claims above. Any account balance remaining unpaid sixty (60) days after provision of treatment may be forwarded to a collection agency and/or attorney for resolution. All costs incurred in collecting unpaid fees will be charged to your account.

Appointment Responsibility

A \$50.00 fee may be assessed to your account if you fail to show for an appointment time, or the appointment is changed or cancelled less than 24 hours prior to the appointment time. Two or more occurrences of such failure to show, late changes, or late cancellations may be grounds for dismissal from the practice.

Parent/Guardian Guidelines

We welcome you to choose whether to be present with your child during treatment. If you choose to be present, we request that you assist us in accomplishing the most comfortable and productive treatment for your child by allowing us to prepare your child, supporting our terminology, being a silent observer, and being willing to be absent from treatment if necessary to enhance communication between your child and the dentist and staff.

Informed Consent for Treatment

I grant permission to the doctor and staff of Pediatric Dentistry, P.C., to provide my child's dental treatment which may include, but is not limited to radiographic, restorative, local anesthetic, nitrous oxide, oral surgical, behavior management, and protective stabilization techniques which are reasonable, necessary, and advisable for the treatment of children. The risks, benefits, and alternatives of all treatment and techniques have been discussed with me and all of my questions have been answered. If, during treatment, unforeseen conditions are revealed which necessitate an extension of the original procedure or a different procedure than planned, I authorize such procedures as are necessary and desirable in the exercise of the dentist's professional judgment. I understand that dental medicine/surgery is not an exact science and a precise outcome or perfect result is not guaranteed.

By signing below, I attest that I understand the Financial and Appointment Responsibility statements and Parent/Guardian Guidelines. By signing below, I also attest I understand the Informed Consent for Treatment and grant such informed consent.

Signature of Parent or Guardian

Date

Relationship to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I indicated that I have received a copy of this office's Notice of Privacy Practices.

Signature of Parent or Guardian

Date

Relationship to Patient