

OFFICE POLICIES

We make every effort to honor your appointment time. However, as a pediatric dental practice emergencies are inevitable. Therefore, maintaining a strict schedule is not always possible. Patients are called back according to the type of procedure they are scheduled for, and not first come first served.

It is the **parent/guardian's** responsibility to be aware of all insurance maximums, deductibles, coinsurance, and services covered. It is recommended by the American Academy of Pediatric Dentistry to have fluoride treatment twice a year. However, if the insurance does not cover it, it is the parent/guardians responsibility to notify us not to give treatment. Once treatment is rendered, payment is due. **Children covered under Cigna HMO Insurance will need their parent/guardian to contact their insurance company regarding the age limitations for a pediatric specialist.**

Every patient is given a treatment plan if any restorative procedures are recommended. The treatment plans are only **estimated** fees. Exact amounts and balances are unknown until treatment is complete and claim is processed and received. **The parent/guardian is responsible for their co-pay portion on the day services are rendered.** For all hospital cases, please refer to your hospital instructions sheet.

Children age six and under are only seen in the morning during the hours of 9:00a.m. and 11:30a.m. If your child is scheduled for a procedure in our office and he/she is not cooperative for treatment, there will be an office visit fee of \$53.00 regardless of any service rendered.

To avoid additional fees, a 24-hour (business day) notice (from the time of your child's appointment) is required for any rescheduling or canceling of an office appointment. **A 72 hour (business day) notice (from the time of your child's appointment) is required for rescheduling or canceling appointments made on student/regular holidays, for families of two or more children, and for appointments made for an hour or more.** You may be asked to reschedule your child's appointment if you arrive 10 minutes or later. For all hospital cases, please refer to your hospital instructions sheet.

Disclaimer: Payment is due in full at the time services are rendered. **Cash, check, and Visa/MasterCard are accepted.** The parent/guardian is ultimately responsible for any and all fees incurred. If dental insurance is filed, the estimated co-pay portion is due in full at the time services are rendered. **A processing fee of \$5.00 is applied to your estimated co-pay if you are unable to pay at the time of the appointment.** The parent/guardian is further responsible for any amount discounted or disallowed by the insurance plan, except in the case where the amount is a contractual discount. If the insurance does not remit payment within 60 days, the full balance becomes the obligation of the parent/guardian, and it is then their burden to collect from the insurance carrier. **Accounts 30 days overdue are subject to a monthly late fee.** If an account should ever require collection action, the parent/guardian will be obligated to pay any and all collection fees.

Chaperone Consent: A chaperone consent slip is required for children accompanied to their appointment by someone other than their parent or legal guardian. This form authorizes the chaperone to consent to and render services for any recommended treatment without the presence of the parent/guardian. The chaperone must be prepared to take care of any and all co-pays due at the time of the appointment.

Parental Consent: I understand the information that I have given is true and correct to the best of my knowledge. It will be my responsibility to notify the office of any changes in my child's medical status, dental insurance, and address or phone numbers. I also authorize the Doctor and Staff to perform the necessary dental services that my child may need.

Patient Name: _____ **DOB:** ____/____/____

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