

OFFICE POLICIES

We make every effort to honor your child's 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** responsibility to be well informed of their insurance coverage. This includes but is not limited to maximums, deductibles, coinsurance, frequency, and for services covered. For preventive and diagnostic services performed every six months, our office provides a periodic exam, prophylaxis, fluoride treatment, and x-rays as needed. It is recommended by the A.D.A. and A.A.P.D. to receive fluoride treatment twice a year. However, if your insurance company disallows the fluoride treatment due to frequency limitations, it is the parent/guardian responsibility to notify us not to render such treatment. Regrettably, our office is unable to recall each and every patient(s) individual insurance coverage. Therefore, once treatment is rendered the parent/guardian is responsible for payment in full.

Every patient is given a treatment plan if there are any procedures recommended in addition to the regular six month re-care. The treatment plans are only **estimated** fees. As a courtesy, we will file the claim with your dental insurance company. However, exact co-pay/co-insurance amounts are unknown until treatment is completed and the claims is submitted, processed, and is received by the insurance company. **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 who are the ages of six and under are usually seen in the morning during the hours of 9:00a.m. and 12:00p.m. If your child is scheduled for a procedure (not a re-care) 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. This uncooperative fee is not payable by your dental insurance company.

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 who have two or more children scheduled, and for appointments made for a blocked time of an hour or more.** You may be asked to reschedule your child's appointment if you arrive 15 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 for all none insured patient(s). **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 for treatment performed at the time services are rendered. 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 60 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, attorney, and legal fees.

Due to Cigna HMO/DHMO restrictions regarding children over the age of six, the parent/guardian must contact their insurance company regarding the age limitations for a pediatric specialist.

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:** ____/____/____