CONSENT - Office Policies, Treatment - Financial Agreement

FAMILY ACCOUNT NAME: _____

FOR STAFF USE ONLY

Reviewed cancellation and insurance policies with parent /guardian/ guarantor.

Reviewed by: _____ DATE: _____ / _____ / _____

APPOINTMENTS / CANCELLATION

I acknowledge that I am to arrive on time for scheduled dental appointments. I understand that **forty eight (48) hour notice is required if I need to cancel or change a scheduled dental appointment**. Less than 48 hours' notice, or not showing for an appointment, is considered a missed appointment. A fee of $35/per patient may be assessed for each missed appointment. I understand that a parent, guardian, or authorized agent is required to accompany all minor patients and must stay for the duration of the appointment. _____ Initial

PAYMENT

I understand that all accounts are due and payable at the time of service. Payment can be made by cash, check, Visa or MasterCard. I understand there is a fee of $35 for any checks returned by the bank, and if my check is returned more than twice, Smile Pediatrics will no longer accept checks from me. I understand that if I send my child to an appointment with an authorized agent, who is not a parent or legal guardian, I must make PRIOR arrangements for payment. Payments are accepted over the phone. Fees for any treatment diagnosed will be discussed with me at the initial appointment. I understand and accept that I am responsible for all costs of dental treatment, regardless of insurance coverage. _____ Initial

INSURANCE

I understand that insurance is a contract between me and my insurance company; Smile Pediatrics is NOT a party to this contract and is not able to negotiate insurance claims for me. All insurance co-pays and deductibles are due at the time of treatment. **My insurance will be billed for me as a courtesy, however, Smile Pediatrics can make no guarantee of coverage. Although it might be estimated what my insurance company may pay, it is my insurance company that makes the final determination of payment and my child's eligibility. I agree to pay any portion of the charges not covered by insurance.** If the insurance company has not paid within 60 days of services rendered, the balance will be automatically due and payable by me. An annual interest of 18% will be charged for any unpaid balance on my account. _____ Initial

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Danielson and his staff to examine, clean, take dental x-rays, use anesthetics, and provide dental treatment on my child as considered necessary by Dr. Danielson. I further understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to, or different from, those listed on the patient's treatment plan. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives.

OTHER

I will allow photographs to be taken of my child or my child's teeth for diagnostic and record keeping purposes. _____ Initial

I agree to inform the office of any changes in address, phone number, employment, insurance, etc. that occur during the course of treatment for my child. _____ Initial

I have read a copy of the Dental Board of California Fact Sheet on Dental Materials and have received a copy if I requested one. _____ Initial

I have read a copy of the HIPPA information and have received a copy if I requested one. _____ Initial

I confirm that I am a legal guardian to the child/children referenced below. I also confirm that I have read and understand this form or it was read to me, and that all sections were initialed by me for all of the patients listed and/or associated with my family account.

PATIENT NAME: _____ PATIENT NAME: _____

PATIENT NAME: _____ PATIENT NAME: _____

PATIENT NAME: _____ PATIENT NAME: _____

Signature of Parent/Legal Guardian/Financial Guarantor: _____ Date: _____ /_____ /_____

REVISED 05/21/18

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