FINANCIAL POLICES, OFFICE POLICIES, ACKNOWLEDGEMENT AND AUTHORIZATION FOR SERVICES

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients and their insurance plans for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that they (patients, parents or legal guardian) are personally responsible for payment of all dental services. This office will prepare and submit the patient's insurance forms, make collection from insurance companies, and will credit any collections to the patient's account. However this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Insurance deductible, copay and any fee not paid by the insurance company will be estimated and is to be paid at tha time services are rendered.**

Due to constant changes in insurance policies, it is no longer an easy task to interpret every individual policy. Although we try to stay on top of the changes, it is not always possible. We urge you as the parent/guardian to check with your insurance company regarding your policy coverage. It is your responsibility to know your coverage. Failure to comply with this suggestion could result in you as the parent/guardian being responsible for all costs incurred during your child's visit with the Doctor. **Your insurance policy is between you and your insurance company, not between the Doctor and the Insurance Company.**

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or the behalf of my dependents. I agree to pay additional charges associated with the costs of collection if my account becomes delinquent including reasonable attorney's fees, court costs, finance charges and the legal rate of interest on the account until paid in full.

Accepted forms of payment: Visa, MasterCard, Cash, Discover, American Express. **No checks accepted.**
$25 Fee per half hour of missed, late appointments.

Your child's appointment is reserved specially for him/her. All reasonable effort will be made to confirm the appointment with you. **If you failed to show for an appointment, arrived more than 10 minutes late, or cancelled less than 24 hours prior to the reserved time without extraordinary circumstances, it will be considered a missed appointment. Two or more occurences of such missed appointment, late charges or cancellations may result in a $25 fee (per half hour of appointment scheduled) on your account on the dismissal from the practice. If your child refuses treatment after reasonable attempt has been made, we reserve the right to charge an office visit fee of $25 (per half hour appointment scheduled).**

Authorization of Service:

I authorize the diagnosis of my child's dental health by means of comprehensive examination, digital radiographs, study models, photographs or other diagnostic aids deemed appropriate. I also authorize aforementioned diagnostic materials may be used for purpose of professional consultations, research, education or publication in professional journals. I further authorize any recommended dental cleaning and topical fluoride treatment.

I authorize Kids Healthy Smiles to release any information including the diagnosis and records of treatment or examination for myself or my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners, for purpose of facilitating care and/or obtaining reimbursement. I acknowledge that I read the HIPPA notice of Privacy Policies. I understand that once released, doctor and Kids Healthy Smiles have no responsibility for any further release by the individual receiving this information. I authorize payment from my insurance carrier to submit payment directly to dentist or Kids Healthy Smiles to be applied directly to any outstanding balance on my child's account.

Your Child's (patient's) Name

_____/_____
Last Name First Name

_____
Signature of Patient, Parent or Legal Guardian