OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve your family in a comfortable and professional atmosphere. Our goal is to provide your family with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **Fees for services at our office will be requested and expected on the day of service.**

- For patients with Dental Insurance:

  We will file your claim for you at *no charge*, however, we ask that your deductibles and your estimated portions (20-80%) be paid as services are rendered. Although we gladly file dental insurance claims, any and all account balances are ultimately your responsibility.

  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

- Please note for your convenience, we do accept VISA, MasterCard, Discover, American-express, and Care Credit and cash payments.

OFFICE POLICIES

- Your appointment time is set aside especially for your child. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we would require a 48-hour notice. Repeated cancellations or failures will result in a broken appointment charge of $50.00, or no reappointment. <u>This policy will be enforced on all appointment made for Dental Treatment.</u>**

- We realize that many families are in a state of change. **The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.**

- We will be fair in working out special finances with you, but please also be fair to us with your commitments. ***A 1.5% finance charge will be assessed monthly on all overdue balances.***

CONSENT:

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my child's health or change in their medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Parent/Guardian Signature _____