FINANCIAL AGREEMENT AND OFFICE POLICIES

STATESBORO Pediatric Dentistry

We appreciate the opportunity to serve you and your child. It is our intention to provide your child with the finest dental care possible, while ensuring that you fully understand procedures, treatment and payment expectations and office policies.

Please rear*/ carefully, initial and sign the accompanying form. If* you have any questions, please *ask the front desk* personnel.

PAYMENTS

• We ask that all payments or co-payments be made at the time of service unless other arrangements have been made in advance. This includes applicable deductibles, coinsurance and copayments for participating insurance companies. For your convenience, we accept check, cash, Visa, MasterCard and Discover. There is a service charge of $25.00 for all returned checks.

• As a courtesy, we will provide each patient with a treatment estimate according to the information obtained from your insurance company. Please remember that an estimation of benefits is not a guarantee the insurance carrier will pay that amount.

• Patients without insurance or any remaining insurance benefits available are expected to pay the balance in full prior to treatment.

• Balances owed by the patient or responsible party that are over 30 days will accrue a finance charge of 1.5% that will be added to the account for each month that the account is past due. This represents an annual percentage rate of eighteen (18%) percent (APR).

Initial _____

INSURANCE

• Our office provides dental care as determined by the American Dental Association and the American Academy of Pediatric Dentists. Insurance companies may have limits or exclusions for the recommended treatment. It is up to you to know your insurance policy and any possible limitations and exclusions.

• Our office is happy to bill your insurance(s) for you at no charge. To avoid confusion, it should be understood that insurance billing is an elective service provided to our patients. Difficulty obtaining insurance payment may occur, and insurance payments CANNOT be guaranteed. The parent/guardian and/or guarantor are solely and ultimately responsible for payment.

• If we do not receive payment from your insurance company within 45 days of date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or your insurance carrier. Complete and accurate insurance and subscriber information is required in order to extend the courtesy of filing your insurance claim for you.

Initial _____

REFUNDS AND FEES

• If your insurance pays more than expected after payments of coinsurance and copayments, we will automatically refund these amounts to the guarantor via a check.

MISSED APPOINTMENTS, LATE CANCELLATIONS, BROKEN APPOINTMENT FEES

• Except in emergency situations, you can expect us to be on time for you and we will appreciate the same courtesy. Your appointment time is reserved for you and your child alone, and without notice in advance we are generally unable to make use of missed appointment time. Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. *Cancellations* are *requested at least 24* hours prior to the *appointment.*

• *A* fee of $35 *is* charged for *appointments missed* or *broken with* less *than 24 hours* notice.

• *If a patient* **cancels** *late (less than 24* hours) *or doesn't* show *up for his/her appointment* more *than* once, *that patient may* be *dismissed as a patient* of the office.

REFUNDS AND FEES (cont.)

• If your schedule does not permit you to plan in advance, we might suggest placing you on our list of patients to call on a short notice basis.

Initial _____

OFFICE POLICIES

• The parent/guardian is fully responsible for monitoring and assuring their child's appropriate behavior and activities while in the waiting areas or front office.

• To avoid distracting the dental professionals while your child is receiving dental care we only recommend a single adult to be present in the room. If you have more than one young **child who needs adult supervision, we suggest that you make arrangements for a second adult to be present in the waiting area during your child's appointment.**

• To maintain our employee's as well as patient's privacy, NO PHOTOGRAPHY and NO VIDEOGRAPHY is allowed in the treatment rooms. If another person is present in your frame in other non-clinical areas of the office, please ask permission first before taking a photograph.

• Parents/guardians are not allowed to stay in the treatment room when the dental treatment is being done under general anesthesia or sedation, but can escort their child to the treatment room.

• Children who need procedure(s) beyond the scope of Pediatric Dentistry will need to be referred out to a general dentistry practice or another dental specialist as needed. Children who have lost all primary (baby) teeth will be graduated to see a General Dentist to establish a new dental home for continual dental care.

• *Please refrain from using your cellphones, especially when you are in the treatment rooms.*

• **NO FOOD OR DRINKS** are allowed in the clinical/treatment rooms.

Initial _____

AUTHORIZATION FOR MUTUAL EXCHANGE OF INFORMATION

• I / We hereby authorize mutual exchange of information between providers of Statesboro Pediatric Dentistry 613 E. Grady Street, Statesboro, Ga. 30461. And any other medical or dental provider (except:____) for our child necessary **to provide** appropriate **dental** care.

• The following information from his/her records can be obtained: X-Rays, Medical and Dental records

Indicate nature or extent of information: _____

• The above information is to be released for the following purpose only: Dental Treatment and update Medical/Dental **history.**

• I understand that I may revoke this authorization at any time, except to the extent that action has been taken based on this authorization before it is revoked.

Initial _____

ACKNOWLEDGEMENT

I have read and understand this authorization. *I* have *asked questions about anything that was not* clear *to* me and *I am* satisfied *with the answers I have* provided.

Signature of person authorized to sign for patient _____

Relationship to patient _____

Print Name _____ Date _____

NOTICE OF NONDISCRIMINATION

Statesboro Pediatric Dentistry complies with applicable Federal **civil rights** laws and does **not discriminate** on the basis of race, color, national **origin,** age, **disability, or** sex.
613 East Grady Street, Statesboro, GA, 30458