Parent / Guardian Name(s): _____ _____

Children's Name(s): _____ _____ _____ _____ _____ _____

Financial Responsibility

Fees for treatment are due at the time of scheduling. A written estimate of treatment cost will be provided prior to provision of treatment. Payment methods include cash, check, credit card, and a no-interest payment program (CareCredit). Returned checks will be assessed a $30 fee. Post-dated checks are not accepted. For most dental insurance plans we will help file the dental insurance claims for you. We are not contracted with Medicaid.

Dental insurance is a contract between you and your insurance company, and in most cases your dental insurance company will not pay for the entire cost of treatment. We are not responsible for how your dental insurance company processes its claims or for what benefits they pay on a claim. We can only assist you in *estimating* your portion of the cost of treatment; we at no time guarantee what your insurance will or will not do with each claim. A monthly finance charge of 1.5% may be applied to account balances which remain unpaid either following 60 days after provision of treatment or after dental insurance claims have been paid. I give permission to ABC Pediatric Dentistry to release my personal information to my insurance carrier as necessary to conduct business with my insurance carrier, and I authorize assignment of benefits as allowed by my insurance carrier.

In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Appointment Responsibility

Please arrive at the start of your scheduled appointment on time. We allow "pre-appointing" of routine checkups six months in advance of the appointment time if desired, and allow "multiple appointments" for siblings during the same day. However, upon the first occurrence of failure to show for an appointment, or upon the first appointment change or cancellation less than 48 hours prior to an appointment, we may not allow "pre-appointing" or "multiple appointments" for these checkups. More than one occurrence of such failure to show for an appointment, or appointment changes or cancellations less than 48 hours prior to the appointment may result in dismissal from the practice. For treatment and OR appointments, prepayment is due at time of scheduling.

Parent/Guardian Guidelines

We welcome you to choose whether to be present with your child during appointments. If you choose to be present we ask that you read and follow the Parent Guidelines information form to better prepare for your child's successful dental appointments. *For treatment appointments, no additional children (i.e. siblings, including infants) will be permitted in the treatment room and only one parent/guardian is allowed. Please plan accordingly.*

Informed Consent for Treatment

I grant permission to the doctor and staff of ABC Pediatric Dentistry to provide my child(ren)'s dental treatment which may include, but is not limited to radiographic, restorative, local anesthetic, nitrous oxide, oral surgical, behavior management, and protective stabilization techniques which are reasonable, necessary, and advisable for the treatment of children. If, during treatment, unforeseen conditions are revealed which necessitate an extension of the original procedure or a different procedure than planned, I authorize such procedures as are necessary and desirable in the exercise of the dentist's professional judgment.

By signing below, I attest that I understand the Financial and Appointment Responsibility statements and Parent/Guardian Guidelines, and have read the additional Parent Guideline form. By signing below, I also attest I understand the Informed Consent for Treatment and grant such informed consent.

_____ _____ _____

Signature of Parent or Guardian | Date | Relationship to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I indicated that I have been offered a copy of this office's Notice of Privacy Practices. (This is available to you on our website or a printed copy can be requested.)

_____ _____ _____

Signature of Parent or Guardian | Date | Relationship to Patient

I consent to the dental practice using my cell phone number to (choose one, both, or neither) ❑ call and/or ❑ text regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My cell phone number is (include area code) _____ _____(initial)

My cell phone number is (include area code) _____ _____(initial)