

Smile Zone

PEDIATRIC DENTISTRY

Specializing in Dentistry for Infants, Children, and Adolescents

Patient Name:

Financial Policy

I have received the Smile Zone financial and insurance policy which outlines my financial responsibility toward care rendered by the doctors at Smile Zone Pediatric Dentistry. ***I understand that the parent or legal guardian who accompanies my child to an appointment will be responsible for payment at the time services are rendered.***

Appointment Cancellation or No-Show Policy

Many patients are waiting months in advance for appointments, please respect our schedule and our other patients by giving us time to fill your reserved spot with another patient in need of care. I take full responsibility for the cancellation of any needed appointments. ***In the event a preventative appointment is missed without a 24 hour notice a \$50 fee will be charged and/or the patient will be dismissed from Smile Zone. The \$50 fee must be collected before another appointment can be scheduled.***

Medical / Dental Release Statements

I give my consent for the doctors of *Smile Zone Pediatric Dentistry* to complete a thorough examination on the patient named above including any needed diagnostic radiographs. To the best of my knowledge the information I have provided is accurate and I understand that it will be held in the strictest of confidence and in accordance to all federal and state HIPAA regulations. Further more, I understand that it is my responsibility to inform *Smile Zone Pediatric Dentistry* of any future changes to my child's medical history status. As a parent or legal guardian of the previously named patient, I also hereby grant the doctors and staff of *Smile Zone Pediatric Dentistry* permission to perform future treatment(s) as deemed appropriate. I understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time services are rendered, unless prior arrangements have been approved.

Insurance Claim Release & Financial Responsibility Statement

To precipitate the filing of this and all future dental insurance claims, I do hereby authorize the release of confidential information to my child's dental insurance company. I am aware that *Smile Zone Pediatric Dentistry* will be providing an estimate of the insurance coverage prior to initiating any future treatment and that I am legally responsible for any portions not paid by this policy. I understand that additional out-of-pocket expenses may be accrued should estimates provided by my insurance company be inaccurate or should procedures change during the course of the treatment. Furthermore, I am aware of my financial responsibility should my insurance policy fail to pay, for any reason, within 45 days of receiving such treatment.

Authorization for Direct Payment

I hereby authorize payment of insurance benefits directly to *Smile Zone Pediatric Dentistry* or the dentist that performs treatment on my child. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

Notice of Privacy Practices, Health Insurance Portability & Accountability Act of 1996

I have read the form entitled, "Notice of Privacy Practices," and understand its contents concerning the privacy of my child's confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Smile Zone Pediatric Dentistry from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

I have read and understand the above policies.

Parent or Legal Guardian Signature

Date

Smile Zone Employee Signature