Office Policies for Summerville Pediatric Dentistry

Appointment Policy

Your child is unique and special to us, and appointment times are reserved exclusively for each patient. Out of respect to you and your busy schedule, we reserve this specific time slot for your child's care, and make every effort to see them at that appointed time. We appreciate your promptness and ask that you not change your appointment unless absolutely necessary. If you do need to change an appointment, we ask that you give us at least 48 hours notice so that we may make the time slot available to another patient. We realize that unexpected things can happen, but ask for you assistance with this regard.

Preschool children and young children with extensive treatment needs should be seen in the morning, since they are fresher and we may work more slowly with them to maintain a good dental experience. Dental appointments are an excused absence. Missing school can be kept to a minimum when regular dental care is maintained.

Financial Policy

A **10% deposit** is required for all restorative procedures. A **150$ deposit** is required for all sedation appointments. This amount will be applied to your out-of-pocket expenses not covered by your insurance. These deposits must be made prior to scheduling the appointment. Failure to notify this office of cancelling your appointment for 24 hours will result in loss of your deposit. **Initials _____**

A missed appointment fee of **50$** will be applied to your account with less than 24 hours notice of cancellation. Repeated failure to keep your appointments without notice may result in our office discontinuing treatment for your children. **Initials _____**

All fees for dental services are expected to be paid at the time of treatment. For your convenience, we accept Visa, MasterCard, Cash and personal checks.

Dental Insurance

We are glad to assist you in obtaining the maximum benefit from your dental insurance plan. Once your coverage has been verified, we will accept assignment of payment from your insurance company. Most plans only cover a portion of the dental fee, which means you will be responsible for your deductible and the estimated co-payment. Your co-payment is expected to be paid at the time of treatment. For your convenience, our office will gladly process your insurance on your behalf, understanding that the agreement you have with your insurance company is between you and them. Therefore, you are responsible for any claims which remain outstanding after 60 days, and a finance charge will be applied to any balance due. Payment will be expected on any such claims, and no further attempt will be made by our office to collect from the insurance company in this event.

The parent or guardian who brings the child to the appointment will be responsible for payment in full. All statements will be sent to this individual. We will not bill a third party other than insurance companies.

If you have any questions regarding this policy, please speak with someone from our office prior to treatment. We will not alter financial arrangements once treatment has been started.

I have read the above financial policy and understand my obligation to Summerville Pediatric Dentistry.

Please **print** child(ren's) name(s) _____

_____ _____

(Responsible party signature) (DATE)

Acknowledge of Statement of Privacy

I acknowledge that a copy of the Statement of Privacy Practices for the office of Summerville Pediatric Dentistry is available to me. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices is also posted in the facility.

Summerville Pediatric Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. A copy of the revised Statement of Privacy Practices will be available upon request and will be posted in the facility.

I give my permission to Summerville Pediatric Dentistry to use my and/or my child's picture on their website for educational purposes.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (PLEASE SPECIFY):_____	YES	NO

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