FINANCIAL POLICIES, OFFICE POLICIES, ACKNOWLEDGEMENT, AND AUTHORIZATION FOR SERVICES

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients and their insurance plans for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that they (patients, the parents, or legal guardian) are personally responsible for payment of all dental services. This office will prepare and submit the patient's insurance forms, make collection from insurance companies, and will credit any collections to the patient's account. However this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Insurance deductible, copay, and any fee not paid by the insurance company will be estimated and is to be paid at the time services are rendered. Occasionally the insurance company will downgrade a posterior composite (D2391, D2392, D2393, D2394) and only pay for a comparable amalgam filling. We do not do amalgam fillings at our office. If you choose to have a posterior composite done at our office you understand and agree to pay the cost of the upgrade (which is the difference between the silver (amalgam)filling and the tooth colored (composite) filling.**

Due to the constant changes in insurance policies, it is no longer an easy task to interpret every individual policy. Although we try to stay on top of the changes, it is not always possible. We urge you as the parent/guardian to check with your insurance company regarding your policy coverage. It is your responsibility to know your coverage. Failure to comply with this suggestion could result in you as the parent/ guardian being responsible for all costs incurred during your child's visit with the Doctor. **Your insurance policy is between you and your insurance company, not between the Doctor and the Insurance Company.**

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or the behalf of my dependents. I agree to pay an additional charges associated with the costs of collection if my account becomes delinquent including reasonable attorney's fees, court costs, finance charges and the legal rate of interest on the account until paid in full.

Accepted Forms of Payment: Visa, MasterCard, Cash. **No checks accepted.**

$25 Fee per half hour of Missed or Late Appointments:

Your child's appointment is reserved specially for him or her. All reasonable effort will be made to confirm the appointment with you. **If you failed to show for an appointment, arrived more than 10 minutes late, or canceled less than 24 hours prior to the reserved time without extraordinary circumstances, it will be considered a Missed Appointment Missed Appointments, late changes or cancellations may result in a $25 fee (per half hour of appointment scheduled) on your account or the dismissal from the practice.**

Authorization of Service:

I authorize the diagnosis of my child's dental health by means of comprehensive examination, digital radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I also authorize aforementioned diagnostic materials may be used for purpose of professional consultations. I authorize the doctors at Mini Mouths to provide dental services, prescribe and dispense and/or administer and drugs, medicaments, antibiotics, and local anesthetics that they might deem necessary or appropriate to my care. I am informed that there are inherent risks involved and that it is mandatory that I follow any instructions given by the dentist and take any medication as directed. No guarantees are made as to the result of treatment.

I authorize Mini Mouths Dentistry For Kids to release any information including the diagnosis and records of treatment or examination for myself or my dependent (s) to third-party insurance carriers, payers, and/or healthcare practitioners, for purpose of facilitating care and/or obtaining reimbursement. I acknowledge that I received the Notice of Privacy Policies. I understand that once released, doctor and Mini Mouths Dentistry For Kids have no responsibility for any further release by the individual receiving this information. I authorize payment from my insurance carrier to submit payment directly to dentist or Mini Mouths Dentistry For Kids to be applied directly to any outstanding balance on my or my child's account.

Your Child/Children's (Patient's) Name

_____ / _____

_____ / _____

_____ / _____ __

Signature of Patient, Parent, or Legal Guardian:

X _____ _____ **Date** _____

Sign and Print Name Relationship to Patient