

OFFICE PROCEDURES REGARDING PATIENTS WITH TREATMENT AND CONSENT

Our goal in treating your child is to provide the highest quality care utilizing the most up to date techniques and materials in a safe, friendly environment by our experienced, caring, and well-trained staff. It is our goal to prevent decay and have all of our patients "cavity-free" with great oral health.

However, there are times when treatment is needed. The doctor will discuss the recommended treatment with you and give you the written treatment plan to review. The following are our guidelines for treatment, which we will discuss with you. If you have any questions or concerns regarding these guidelines, please feel free to ask any of our staff doctors, or one of our staff members at any time.

TREATMENT

We will treat your child the same way we would treat one of our own children while providing dental care to them—with tender, loving care, and honest, sincere concern without strong sedative drugs. We will at times use Nitrous Oxide to help your child relax. The doctor or our staff will discuss this with you prior to the use of Nitrous Oxide.

Since many adults have a fear of dentistry, they wait until they have a serious problem to seek treatment. Most of the treatment we perform on children, such as sealants and small fillings, is to prevent these serious problems. Our goal is to teach your child that dentistry is a health care service that can provide a lifetime of healthy teeth and gums and having dental treatment can be a positive experience. Our job is to educate you and your child about dentistry and establish trust and confidence in your child about dental treatment.

We encourage parents to accompany their child during their initial exam and for routine dental cleanings. However, if your child needs treatment we respectfully ask that whoever accompanies the child to their appointment wait in our lobby. At the doctor's discretion some situations may allow for exceptions. Our staff will discuss this with you prior to any treatment. This allows the doctor to establish a direct and close rapport with your child. When a parent is in the room, your child's attention is divided and it is difficult to gain his/her confidence. Most children handle the situation better without the parent present. One of our staff members will come to the reception room and accompany your child to the treatment room. They will stay with your child during treatment and accompany your child back to the reception room after treatment is finished. While you may feel it is a comfort for your child to "walk them back to the room", we have found this to be a greater problem for your child, because you are "leaving" him/her. If your child knows you are "waiting" for him/her "out front" and he/she will join you at the end of treatment, then you have not "left" or "gone away." We schedule all operative treatments, such as filling and extractions, in the morning. We have learned from past experience that children are more receptive to this type of treatment in the morning.

CONSENT

Your child is a minor; therefore it is necessary to obtain signed permission from a parent or guardian before any necessary dental service can be provided. **THE PARENT OR GUARDIAN WHO BRINGS THE CHILD FOR DENTAL TREATMENT IS RESPONSIBLE FOR ALL FEES.** We will be glad to give you the proper receipts necessary for you to get reimbursement, if another party is responsible for the child's health care costs.

I grant the doctor permission to provide my child's dental exam and treatment, including x-rays, study models, photographs, and/or any other diagnostic aid deemed necessary to make a thorough diagnosis, and perform any treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I will be responsible for all costs of this dental care. I authorize Hendricks Pediatric Dentistry to send a dental report to my child's physician, and/or referring dentist. I authorize the release of any medical information necessary to process insurance claims, and I also request payment of benefits to the dentist. However, if I pay in full at time of service, insurance benefits will be paid directly to me. In the event that it would be necessary to involve a third party to collect all or any part of an amount owed to John R. Wells, D.M.D., P.S.C., they are entitled to the cost of collection. I acknowledge that the above policy has been explained to me along with the recommended treatment, and that my questions have been answered to my satisfaction. Also, by signing this document I acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. (You may refuse to sign this acknowledgement. However we will not be able to file insurance and payment in full will be due at time of service. Please understand that revocation will not affect any action we took prior to this consent, and that we may decline patient treatment if you revoke this consent.)

AUTHORIZATION

I have read & accept the above policies. I understand & agree to the terms set forth regarding payment. I understand that the above policies apply to all individuals under my account.

Patient(s) Name(s): _____ Date _____

Signature of guardian: _____ Relationship to patient(s): _____

Printed Name of Guardian: _____

APPOINTMENT AND FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. ***It is our policy to make definite financial arrangements with you before any treatment starts.*** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

- **Please be on time** for your appointment. **If you cannot make your scheduled appointment and do not call in advance to reschedule or cancel your appointment**, your appointment will be considered as a **“Broken Appointment”**. (This time could have been used to treat another child if we knew you were unable to make your appointment). If the appointment was for a **new** patient, we will **not** be able to accept that child as a patient. We reserve the right to charge a fee for any missed appointment and/or dismiss the patient from our practice.
- Always bring the patient’s insurance card.
- Please notify us of any changes of address, phone numbers, and insurance coverage as soon as possible.
- Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards. There will be a \$30.00 service charge for all returned checks.
- For new patient emergency visits we require payment in full at the time of the appointment.
- **As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for your reimbursement or you may assign the payment to our office and we will file the insurance for you**
- Our office will file your insurance claim a maximum of **two times** per appointment.
- **If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.** We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.
- You must provide the office with a dental insurance card with the proper mailing address of the insurance company, or provide a dental claim form, which is provided by the employer. If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.
- If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. However, if your insurance company does not assign benefits to the doctor, your payment in full is expected at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company’s usual and customary fee schedule.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.
- **The office cannot carry balances longer than 90 days**, regardless if the insurance payment is still pending. We reserve the right to charge billing fees and or employ a collection service to collect payment on accounts with balances older than 90 days. If your account is delinquent, we will not be able to reserve appointment times (other than emergencies) until your account is current.
- **The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree or custody arrangement may state. Reimbursement must be made between the divorced parents. We will not intervene.**

AUTHORIZATION

I have read & accept the above policies. I understand & agree to the terms set forth regarding payment. I understand that the above policies apply to all individuals under my account.

Patient(s) Name(s): _____ Date _____

Signature of guardian: _____ Relationship to patient(s): _____

Printed Name of Guardian: _____