

## Office and Financial Policy

- **Please Note:** All appointment times are guidelines only. The doctor will spend as much time as needed to meet each patient's individual needs. This, as well as emergency cases, can result in a delay in the daily schedule. We ask for your patience.
- **Minor Child:** It is required that the legal guardian accompany their minor child to each appointment, unless a consent form and payment arrangements have been taken care of prior to the scheduled appointment. If there is more than one child from the same family, we must have a separate consent form for each child. The adult accompanying the child must also bring a copy of the child's current insurance card.
- **Operatory Requirements:** One person may accompany the patient to the treatment room. We ask that a responsible adult be present in the waiting room if you choose to bring other children to the appointment. We do, however, encourage patients to be solo for their operative (fillings). We require the child to be independent (solo) for all orthodontic appointments. This helps to foster independence and self confidence. This also allows our staff to fully focus on your child, thus creating a positive dental experience. Instructions for operative appointments are given at the time of scheduling. **If you arrive to the operative appointment and treatment is aborted or not able to be performed due to patient's behavior, or have not followed all the guidelines; it is possible that the appointment may need to be rescheduled and an office visit fee applied.**
- **Required Paperwork:** The medical history form needs to be updated every 12 months. We also require that you present your insurance card at check-in to ensure that we have your most current coverage on file. If there is more than one family member in the practice, paperwork must be completed for each individual.
- **Co-pay:** Your insurance policy is a contract between you and your insurance company. We are not in that contract. If you are an enrollee of a PPO or HMO that we are contracted with or with a traditional insurance plan, you are required to pay the co-payment each time that you are seen. This must be paid at the time you check-in for your appointment. If you are not prepared to pay the amount you agreed to in your insurance contract, the visit must be rescheduled. We will re-file your insurance claim for a total of two times. After 90 days, the follow up with your insurance company and remaining balance is your responsibility.
- **Release of Medical Records:** Requests for copies of medical records requires two-week notice. Original records are not allowed to leave our office. A release form must be completed and signed by the patient, or guardian of patient, and accompanied by payment of \$15.00 per family member, prior to records being sent.
- **Missed Appointments:** Any appointment that is not kept or cancelled **without giving 48 hour notice** will be considered a "no show". The time that was reserved, for your child, prevented another patient from receiving our specialized services. **For this reason, "no shows" will be charged a fee of \$30.00 for their unused appointment time.** This fee will be billed directly to the person responsible for the account, not to insurance. A third "no show" may be regarded as termination of treatment by the parent or legal guardian and necessitate formal dismissal from the practice.
- **Past Due Accounts:** I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection fees and attorney fees. Accounts exceeding 90 days will accrue an interest charge.
- **Returned Checks:** I understand that there is a \$30.00 fee for checks returned by my bank due to insufficient funds and agree to immediately make payment, in cash or money order, upon notification that my check has not cleared my bank. I further understand that Pediatric Dental Specialists, PA does not pursue bad checks within the boundaries of the "BAD CHECK LAWS" in the State of Kansas accordance with K.S.A. 21-3707.

We are happy to offer MasterCard, Visa, Discover, American Express and Care Credit as a payment option. I hereby acknowledge that I have read, understand and agree to the terms of this document.

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date