Policies and Consents

PLEASE LIST ALL OF YOUR CHILDREN'S FIRST AND LAST NAMES:

_____

_____

_____

Initials: _____ Required Payments: At treatment visits, we collect a percentage of the total cost of treatment, determined by an ESTIMATION of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will be reimbursed in the same form of payment. The full balance of treatment is due at the time services are rendered. For your convenience we accept cash, check, debit card, credit cards (Visa, MasterCard, Discover and American Express) and Care Credit. Payments can be made in office, by phone, Online or mailed.

Initials: _____ Financial Responsibility: The parent or guardian bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons. In the event of divorce/separation, the party responsible for the account prior to the divorce remains responsible for the account. After the divorce/separation, the parent or guardian bringing the child and authorizing treatment will be the person responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from them. We will provide you additional copies of receipts if needed.

Initials: _____ Insurance: We are happy to file dental claims for our families who have dental insurance! Please know and understand that your dental insurance is a contract between you and your dental insurance company. We file insurance as a courtesy to our patients. It is your responsibility to know and understand your dental insurance coverage in regards to maximums, frequencies and procedures covered and non-covered services. Filing your insurance is not a guarantee of payment. Please understand that the parent or guardian has the final responsibility for payment of any services rendered. Our doctors recommend treatment based on your child's needs, not on what insurance will pay. Therefore, we will do everything possible to maximize your benefits. In the event that your insurance has not paid your account within 90 days, the balance may be transferred to your account. We reserve the right to discontinue or refuse to file a claim.

Initials: _____ Past Due Accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date printed on the statement. A $15.00 late fee may be charged on any account that is not paid within thirty (30) days of the statement date. Balances not paid after 90 days will be considered delinquent and will be sent to a collection agency. Once the account has been placed in collections, the parent/guardian will be responsible for all expenses incurred in the collection process including a $50 delinquent fee.

Initials: _____ Statements: If you have a balance on your account, we will send you a statement in the mail or email. It will show your previous balance, any new charges, and any payments or credits applied to your account. We are on a 30-day billing cycle. If you would like e-statements, please make sure to provide an email address so that we can send statements electronically. We will also send out e-statements via text message; so please make sure we have an updated and correct phone number on file.

email: _____

Initials: _____ Returned Checks: There is a $30.00 fee for any checks returned by the bank.

Initials: _____ When we schedule an appointment for your child, that time is reserved solely for your child. We do not double book and we take pride in the fact that because we value your time, as much as we hope you value ours, we make every effort to see your child at the time scheduled. For this reason, it is very important that you have your child in the office at the time scheduled. If you are more than 10 minutes late, it may be necessary to reschedule your child's visit.

Initials: _____ Canceling or Rescheduling: If you are unable to keep a scheduled appointment, a 48-hour notice is required. We understand that unforeseen emergencies do occur, however, we reserve the right to charge your account a $25.00 fee for repeated last-minute cancellations or broken appointments. Failure to miss 3 consecutive appointments may result in a "same day" appointment basis for any future visits and will depend on our appointment availability.

Initials: _____ Weekend Appointments (Friday/Saturday): Please understand that due to our limited availability for weekend appointments, if you no show or cancel same day, we will no longer be able to offer a weekend appointment.

Initials: _____ I grant permission for Dr. J Pediatric Dentistry to take a picture of my child(ren) for the purpose of his/her personal chart NOT social media. I understand this information will not be shared with outside parties. I release Dr. J Pediatric Dentistry and its employees from any and all claims, demands, causes of actions and suits arising out of or in connection with the use of these photographs, videos or interviews.

Initials: _____ I understand that by providing Dr. J Pediatric Dentistry my phone number, I will receive text message communications related to appointment reminders, healthcare information and billing matters. I understand that I may be charged message and data rates by my wireless carrier. Such messages may be generated by an automated messaging system and I may opt-out of this service in writing to Dr. J Pediatric Dentistry.

Effective Date: Once you have signed this form, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect. This authorization will remain effective unless terminated by written notice. I have read the above policies and understand my obligations with Dr. J Pediatric Dentistry for my child's dental care. I understand that I am financially responsible for any service that my dental insurance plan does not cover. I affirm that my signature represents my agreement to all of the terms mentioned above.

Guardian's Printed Name: _____

Guardian's Signature: _____ Date: _____

Dr. J Pediatric Dentistry
drjpediatricdentistry.com

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Your Child's First & Last Name (Please list ALL siblings)

_____

_____

Below is a list of ways our office may contact you. Please check all that apply. Checking a box will give permission to leave as thorough of a message as needed from our dental office.

☐ Home_____ ☐ Work_____

☐ Cell_____ ☐ Email_____

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize Dr. J Pediatric Dentistry to release any information including diagnosis and the records regarding any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners. In the event of my absence, the following individuals may bring my child/ children to and from their appointments along with have access to medical and financial information**.**

1. _____ _____
Name (Please Print) (Relationship to patient) (Contact Number)

2. _____ _____
Name (Please Print) (Relationship to patient) (Contact Number)

3. _____ _____
Name (Please Print) (Relationship to patient) (Contact Number)

I. _____have been offered a copy of this office's Notice of Privacy Practices.
(PARENT/GUARDIAN NAME)

_____ _____
Print PARENT/GUARDIAN Name **PARENT/GUARDIAN Signature**

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify)_____