

Appointment Policy (Pg 1 of 4)

We are committed to providing your child with the best possible dental care, and we appreciate your cooperation in making this possible.

Please plan to arrive 10-15 minutes or more before your first scheduled appointment. This will allow time to complete any paperwork and see your child on time.

As your child's appointment approaches, we'll contact you to **re-confirm the appointment at least 48 hours in advance**. If we do not receive a response within 24 hours of the appointment time, the appointment will be cancelled.

Your scheduled appointments are reserved specifically for your child. An uncoordinated change in their appointment affects our availability to serve other patients. **If a cancellation is unavoidable, please call the office at least 48 hours in advance** so that we may give the time to another patient. Failure to do so will result in a cancellation fee (\$40 for well-child visits, \$100 for treatment visits, and \$250 for sedation appointments). Appointments cannot be rescheduled if an account has a balance. Certain appointments such as General Anesthesia, Oral Sedation, and Orthodontic procedures require substantial preparation and you will be notified of required non-refundable deposit to secure these appointments.

We are aware of school policies that make missing school difficult. However, with a note from our office, dental appointments are considered excused absences by all schools. To best maximize after-school appointment availability to our patients, we have the following policy:

1- **Children 5 years of age and younger will be scheduled during morning hours**. When the child enters 1st grade, he/she will have access to after-school appointments.

2- All restorative (fillings, crowns, extractions, etc.) procedures are scheduled in the morning. Children are more prepared and better tolerate treatment when fresh in the morning.

We strive to see all patients on time for their scheduled appointment and make every effort to stay on schedule. However, the duration of our appointments are dictated by children's unpredictable ability to cooperate. Also, there are times when our schedule is delayed in order to address an injured child or emergency. Please accept our apology in advance should this occur during your appointment and rest assured we will provide the same courtesy for your child.

If you arrive 10 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.

If two (2) broken appointments or two (2) cancellations occur for consecutive appointments or within a six month time period for any single family, our office reserves the right to NOT schedule any subsequent appointments.

I have read the above policy, and fully understand and accept the terms contained therein.

Child's Name: **XXXPATIENTFULLNAME**

Parent/ Legal Guardian signature provide on last page of document

Financial Policy (Page 2 of 4)

We are committed to providing your child with the best possible dental care. We are very proud of the standard of care we provide and would be happy to help you understand any associated professional fees. Your clear understanding of our financial policy in advance of treatments being rendered is important to our professional relationship. Please be aware that:

The parent/legal guardian bringing the child to Smile Pacific Highlands Ranch is legally responsible for payment of all charges. We cannot send statements to other persons.

Payment in full is required for each appointment as services are rendered. Patients with dental insurance will pay their estimated patient portion at the time services are rendered. For the convenience of our patients, we accept cash, personal checks (which cannot be postdated), MasterCard and Visa. A \$35 fee is assessed for bounced checks.

Dental Insurance – Typically there is **NO direct contract** between our office and your insurance company. Your employer HR and the contract between them and the insurer determines your insurance benefits and coverage. We have learned that insurance company contracts with providers significantly reduce the quality of and access to care. It's our goal to provide the highest level of care regardless of the type of plan chosen by you and/or your employer. To be clear, **we gladly accept and bill all PPO insurance policies** without contracting with insurance companies. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement, or the determination of your insurance benefits. Therefore, we will accept the assignment of benefits as a courtesy to you. However, you are responsible for the payment of your account. Reimbursement for claims filed by Smile PHR should be made to Smile Pacific Highlands Ranch. Any payments not received from your insurance company within 45 days of filing will be billed to you. Once we receive payment from your insurance, if your account reflects an overpayment by you, we will gladly reimburse you.

Emergency Treatment - All emergency treatment fees must be paid in full at the time the service is rendered.

We recognize that under unusual circumstances an account balance may be incurred. Smile Pacific Highlands Ranch requires that all outstanding balances be paid in full within 45 days or services rendered, unless other arrangements have been made. We reserve the right to apply an interest rate of 1.5% monthly from the date of service. Thank you in advance for your understanding of our financial policy.

I have read the above policy, and fully understand and accept the terms contained therein.

Patient's Name: **XXXPATIENTFULLNAME**

Parent/ Legal Guardian signature provided on the last page of the document.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

("Acknowledgement") AND Social Media Notice (Pg 3 of 4)

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

I also am aware that given the widespread use of smart phones, tablets, and other accessories with recorders and cameras by adults and teenagers alike, Smile Pacific Highlands Ranch cannot prohibit the use of these devices by patients/parents/staff. I understand that if I take pictures of my child, I will verbally get permission from those around me. I will make best efforts not to capture any others (child/parent/staff/doctor) and will respect their privacy. Similarly, if the office takes any pictures/video of my child for non-clinical use (such as but not limited to Cavity-free Club, Contest Winner, Facebook/IG Announcement), a verbal consent will be acquired and will suffice by the office in advance.

Child's Name: **XXXPATIENTFULLNAME**

Parent/ Legal Guardian signature provided on the last page of the document.

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

_____ An emergency prevented us from obtaining acknowledgement.

_____ A communication barrier prevented us from obtaining acknowledgement.

_____ The individual was unwilling to sign

Other: _____

Staff Member Signature

Date

General Consent (Page 4 of 4)

CONSENT FOR TREATMENT: The undersigned patient, responsible relative and/or patient's legal representative hereby authorized Smile Pacific Highlands Ranch, its affiliated dentists, and assistants to administer and perform any and all dental examinations, treatments, diagnostic and surgical procedures, or other services which may now or during the course of the patient's care be deemed advisable or necessary. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures. I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement, Smile PHR may disclose portions of the patient's financial and medical records to any person, corporation or to any agent of any such person or corporation which is or may be liable for all or any portion of Smile PHR charges, including but not limited to insurance companies, employers, health service plans or Worker's Compensation carriers. Smile PHR may also make available pertinent information to government social agencies and other health care providers as necessary to ensure continuity of care and availability of health care service for the patient and the patient's family. If release of records is requested, we can prepare them 2 business days after receipt of completed forms. **A \$25 administrative fee is assessed for this service** per child.

HEALTH HISTORY: I have disclosed my child's health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

FINANCIAL AGREEMENT: The undersigned agrees to pay, whether he or she signs as agent or patient, the charges incurred at Smile PHR in accordance with the facility's rates and terms. I understand that while Smile PHR may assist in gathering insurance eligibility/coverage to the best of their ability, this information is not guaranteed. It is my responsibility to investigate procedure costs and benefit coverage/limitations with the insurance company and with the undersigned provider.

I confirm that I understand this form and accept the information contained therein.

Patient's Name: **XXXPATIENTFULLNAME**

Parent/Legal Guardian's Name:

Parent/Legal Guardian Signature

Date