Standard of Care Policy

At a basic 6 month appointment we uphold the *Standard of Care* set by the American Dental Association. These services are...

-Prophylaxis-(Cleaning)
-Fluoride
-X-rays-(Bitewings, Periapicals) (Panoramic-once every 3 years after age 6)
Types are dependant on age and behavior
-Exam

If you **would not** like us to provide one or more of these services during your child's appointment please let us know. Otherwise we will provide this *Standard of Care* to all our patients.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

SIGNATURE_____ DATE: _____

The Use of Nitrous Oxide or "Laughing Gas" Policy

Children generally experience anxiety or nervousness at dental visits which can cause wiggliness and difficulty during procedures. In order to calm patients fears and increase efficiency during appointments, Nitrous Oxide or "Laughing Gas" is administered to most every patient who is having restorative procedures performed.

The use of "Laughing Gas" is extremely beneficial to the patient and has a significant effect on the quality of the work that the dentist is able to perform. Most insurance will not cover this charge, leaving the patient responsible for this fee. If you would like to know the current fee for this service please talk to any or our receptionists.

Although we are a specialist, we choose to keep our fees low to help families afford the quality of dental work they deserve. As a result of this ideal, it is our policy to use "Laughing Gas" on nearly every patient who needs restorative work performed, even though some insurance will not cover the charges.

I have read and understand the above policy.

SIGNATURE_____ DATE: _____

Insurance Policy

ABC Pediatric Dentistry provides their services to you, not your insurance company. Because of this fact, you are responsible for payment of any bill incurred in this office. We cannot provide services assuming that the insurance company will come through with payment. Although as a courtesy to you, we will bill your dental insurance companies for charges incurred in this office. If payment has not been made by your insurance company within 60 days we will expect you to pay the balance in full. You are responsible for all deductibles and charges not covered by insurance. It is your responsibility to understand your own insurance policy and covered benefits and that you are responsible for payment on all non-covered or denied services. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations. That is **Your Responsibility**. Please contact your insurance company to inquire if we are a preferred provider for your insurance.

Our office is happy to be a preferred provider for many insurance companies. Our contract states we will provide a discount for their customers on covered benefits. Since your plan coverage and benefits are contracted between you and your insurance company it is **Your Responsibility** to know what your plan covers. Additionally, some insurance companies consider us a *Specialist*, please be aware of this and what it may do to your covered benefits. Contact your insurance company to inquire if we are a preferred provider for your insurance.

Insurance Billing
On the day of service we will submit all dental claims with the insurance information you have provided. We will allow 60 days for reimbursement from your insurance company. After that time if no reimbursement has been received the balance will be solely your responsibility.

Secondary Insurance Coverage-
If you have secondary insurance coverage we will send any dental claims with the insurance information you have provided. It is your responsibility to know which insurance policy is primary and secondary. Insurance carriers may require additional information from subscribers to determine primary and secondary coverage. It is your responsibility to provide any additional information that your insurance may require. We will allow 30 days from the date we sent the secondary claim to receive reimbursement. After that time if no reimbursement has been received the balance will be solely your responsibility.

Supplemental Insurance Policy-
If you have supplemental insurance, such as Aflac, we will not bill directly from our office unless it's your only insurance. However, we will provide you with a copy of the claim and dental notes upon request. If you would like us to bill from our office, we will charge a $15 charge for this service.

I _____ have read and will comply with the above policies.
I will not hold ABC Pediatric Dentistry responsible for insurance discrepancies
and/or insurance non-payments.

Signature_____ Date_____

Pediatric Dentistry

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. I assign my payable dental insurance benefits to ABC Pediatric Dentistry.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to paid dentist or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree to pay all costs and reasonable attorney fees to collect monies owed by me, including interest charges, processing fees, collection costs/commissions (up to 40% of total due) that may be assessed by any collection agency retained to pursue this matter. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on this and all forms accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____ _____

Signature of Patient(s), Parent, or Guardian Date Relationship to Patient(s)

Pediatric Dentistry

CONSENT TO PROCEED:

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Stanton C. Allen, DDS, Brandon J. Nakken, DDS, and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor(s) or other individual(s) for which I have responsibility, now and in the future, including arrangement and/or administration of any sedation (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to: bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of the treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in very rare cases, require bronchoscopy or other procedures to ensure safe removal. I understand that this situation is atypical.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child/children or ward(s). I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature_____ Date_____
(Legal guardian or authorized agent of patient(s))