

FINANCIAL POLICIES, OFFICE POLICIES, AND AUTHORIZATION FOR SERVICES

Financial Policies:

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients and their insurance plans for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that they (patients, the parents, or legal guardians) are personally responsible for payment of all dental services. This office will prepare and submit the patient's insurance forms, make collections from insurance companies, and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance deductible, copay, and any fee not paid by the insurance company will be estimated and is to be paid before services are rendered.

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

I understand that any fee estimate for this dental care can only be extended for a period of 3 months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I also agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Office Policies:

Your child's appointment is reserved specially for him or her. All reasonable effort will be made to confirm the appointment with you. **If an appointment is missed, arrived more than 20 minutes late, or canceled less than 48 hours prior to the reserved time without extraordinary circumstances, it would be considered a failure to show for an appointment. Two or more occurrences of such failure to show for an appointment, late changes or cancellations may result in a \$50 fee on your account or dismissal from the practice.**

For the safety of patients, staff, and doctors, non-concealed video surveillance is used in Corona Kids Dental. Video data is secured with reasonable efforts for your privacy. In certain circumstances, we may share the data with the police, and/or other entities required by law.

I confirm that I have received a copy of Corona Kids Dental Notice of Privacy Policy.

Authorization for Service:

I authorize the diagnosis of my child's dental health by means of comprehensive examination, digital radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I also authorize aforementioned diagnostic materials may be used for purposes of professional consultations, research, education or publication in professional journals. I further authorize any recommended dental cleaning and topical fluoride treatment.

I authorize the Corona Kids Dental to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners, for purposes of facilitating care and/or obtaining reimbursement. I understand that once released, doctor and Corona Kids Dental have no responsibility for any further release by the individual receiving this information. I authorize the payment from my insurance carrier to submit payment directly to dentist or Corona Kids Dental to be applied directly to any outstanding balance on my or my child's account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Your child's (Patient's) name:

Last Name	First Name	MI

Signature of Patient, Parent, or Legal guardian:

		X					
Print name	Relation to patient		Signature	Date (mm/dd/yyyy)			Witness