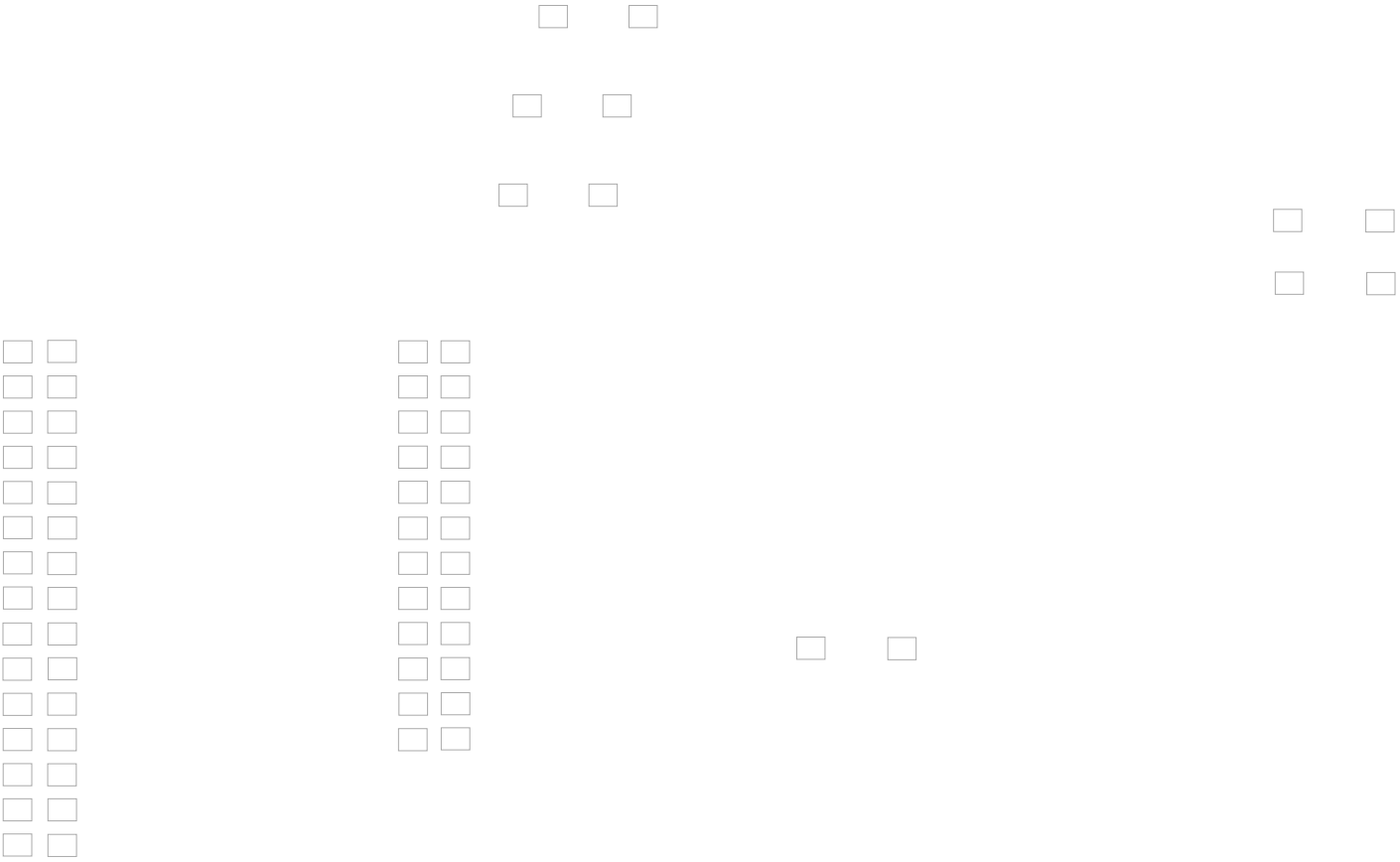
Clear All Forms



ALL KIDS PEDIATRICS DENTISTRY
3007 Wesley Chapel Stouts Rd., Suite A
Monroe, NC 28110
Phone: (704) 684-4451
Fax: (704) 817-6530

APPOINTMENT POLICY

1. All Kids Pediatric Dentistry reserves appointments for your child according to their needs and cooperation. Patients may not be seen in the order they arrive due to their treatment needs and the doctor providing their treatment.
2. As a courtesy, our office will attempt to contact you 1-2 days before your appointment for confirmation. However, we do ask that patients assume responsibility for their appointment time.
3. We recommend arriving 15 minutes before your child's appointment to allow for registration and filling out forms. We also recommend providing your insurance information at least 3 days prior to the appointment in order to ensure the exam or treatment can be performed in a timely manner. Failure to arrive early or provide insurance ahead of the appointment may result in your child being seen later than their scheduled appointment time.
4. For **NEW PATIENT** appointments, it is required that the parent or legal guardian bring the patient. Any subsequent appointments may allow for grandparents or other family members to bring the patient.
5. Parents **CAN NOT** drop the patient off and leave the office. Anyone under 18 must have a parent or guardian in the office at all times.
6. In order to establish trust with your child, we may ask parents to wait in the waiting room while their child is being seen. This will help the patient communicate in their way with the dentist and staff.
7. Broken appointments or short term cancellation (within 48 hours) without proper notification can be costly and unfair to patients who need appointments. Please note: Repeated broken appointments and short term cancellations may be subject to dismissal from the practice.
8. Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day.
9. During the school months, late afternoon appointments are in high demand. We ask that you help us by understanding when we need to schedule during school hours. We will gladly provide you with a school excuse for your child.
10. If your child is under the age of four, we will schedule your child in the morning. This way the child is fresh and more willing to cooperate. This also allows more one on one, uninterrupted time with the dentist.
11. Treatment that require use of Nitrous Oxide or any other medication will most often be scheduled in the morning and on an empty stomach. This helps prevent the child from becoming ill.

Print Name of Parent/Guardian	Patient Name
Parent/Guardian Signature	Date

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FINANCIAL CONTRACT

Thank you for choosing All Kids Pediatric Dentistry for your child's dental care. As we anticipate a long-term relationship with our patients and their families, keeping current in communication and payment is important.

We at All Kids Pediatric Dentistry are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental services available today. We are concerned about your child's dental care and want to ensure that it is performed in a responsible manner.

In order that we may continue to keep our fees as affordable as possible, we must request payment at the time of treatment. We accept cash, Visa, MasterCard, Discover, and American Express. We accept credit card payments over the phone. We also accept Care Credit, which you can apply for in our office, which allows for you to have a convenient monthly payment plan depending upon your credit.

If you have insurance for your child, we will process the claim with your insurance company. We will do our best to give an accurate estimate of your out of pocket expenses. However, these are only estimated out of pocket expenses - we will not have an exact amount of what the insurance company will pay until after they process the claim and provide us, and you, with an "Explanation of Benefits". **All patients are expected to pay for the estimated uncovered portion of your child's care on the day that services are rendered**. We have a traditional "fee for service" structure. Please remember that **you, as the parent, are responsible for any portion not covered by insurance**.

We understand the value of insurance benefits and will assist you in obtaining your maximum benefits. However, we do ask the following: Please read your policy book and/ or talk to your insurance benefits director to be fully aware of any limitations or exclusions. If you have any questions about your insurance coverage, please contact your insurance company. Please keep in mind that your insurance is a contract between you and your insurance company.

LATE PAYMENTS & BROKEN / MISSED APPOINTMENTS

Payment for service is due promptly. A billing fee of $15 is applied for each 60 day period a payment is late.

A fee of $35.00 per child is applied to your account for each broken appointment with less than 48 hours' notice.

Again, thank you for choosing All Kids Pediatric Dentistry for your child's dental health needs. We look forward to caring for your children for many years to come.

Signature of Parent/Guardian	Patient Name
Date	

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name and Address: _____

_____

I have been informed of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written Acknowledgement of Receipt of Notice of Privacy Practices Because:

- An emergency existed and obtaining a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature.
- We were unable to communicate with the patient for the following reason:

  _____
- Other: _____

Prepared by: _____

_____ _____
Signature Date

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CONSENT FOR DENTAL TREATMENT

Patient Name:_____ Today's Date: _____

I, _____, the parent/guardian of the child(ren) listed above, have given Dr. Marcela Mujica and the All Kids Pediatric Dentistry team consent to:

- Take radiographs
- Perform a cleaning and place fluoride
- Provide treatment (restorations, extractions, and appliances)

This consent applies to (check only ONE below):

☐ Today's visit **ONLY**

☐ **Any/All** future visits

Signature:_____

Relationship:_____ Date: _____