

**DENTISTRY FOR KIDS**

**TREATMENT CONSENT, ACCOUNT RESPONSIBILITY AND FINANCIAL POLICY**

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit. We accept Visa, Mastercard, cash, checks, and debit cards. If you have dental insurance, we will be happy to file your claim. Deductibles and estimated copays are due on the day of service. The policy holder is responsible for any balance not paid by the insurance company. We encourage you to check with your insurance company regarding specific coverage and limitations. Please note that Dentistry for Kids uses only composite resin fillings. Some insurance companies limit coverage on these fillings. For larger treatment plans, outside financing is available with low or no interest. Accounts 90 days overdue are subject to collection and additional fees, agency fees, and other charges may apply. There may be a charge for appointments broken or cancelled with less than 48 hours notice.

Father \_\_\_\_\_ Mother \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father Social Security Number \_\_\_\_\_ Mother Social Security Number \_\_\_\_\_

If you have dental insurance, please complete the following:

Primary Insurance Plan \_\_\_\_\_ Phone Number \_\_\_\_\_

Subscriber \_\_\_\_\_ ID or Social Security # \_\_\_\_\_

Group Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_

Secondary Insurance Plan \_\_\_\_\_ Phone Number \_\_\_\_\_

Subscriber \_\_\_\_\_ ID or Social Security # \_\_\_\_\_

Group Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_

*Being the parent or guardian I do voluntarily consent to the performance of examinations, diagnostic procedures (including x-rays), fluoride treatments, sealants, extractions, and resin fillings or stainless steel crowns for my child. I understand this consent will remain in effect for as long as the patient remains an active patient with Dentistry For Kids, Inc. I understand that I may obtain a Notice of Privacy Practices upon request.*

*I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize assignment of my insurance benefits directly to the provider, and authorize the provider to release any information required to process insurance claims. I understand the above information and certify this form was completed to the best of my knowledge, and understand it is my responsibility to inform this office of any changes to the information I have provided.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian