HARRISONBURG
PEDIATRIC DENTISTRY

ACCOUNT INFORMATION

Child's Name _____ DOB _____
Child's Address _____ City _____ State _____ Zip _____

Mother's Name _____ SSN _____ DOB _____
Mother's Address _____ City _____ State _____ Zip _____
Mother's Employer _____ Occupation _____
Home Number _____ Cell Number _____ Work Number _____

Father's Name _____ SSN _____ DOB _____
Father's Address _____ City _____ State _____ Zip _____
Father's Employer _____ Occupation _____
Home Number _____ Cell Number _____ Work Number _____

Person Responsible for Appointments _____ Relationship _____
Preferred Phone Number _____ Email _____

POLICIES

We appreciate you allowing us to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding, we offer these explanations of our office policies.

CONSENT FOR DENTAL TREATMENT: By law, signed permission is required from a parent or legal guardian before any necessary dental service can be started. I request and authorize Dr. Sarah N. McKnight and her staff to provide dental services including, but not limited to, dental examination, diagnostic radiographs, cleaning, fluoride treatment, and necessary treatment (after consultation).

FINANCIAL POLICY: Please help us avoid the high cost of billing by paying when treatment is rendered. The parent or legal guardian bringing the patient to our office is responsible for payment of the account. Delinquent accounts (over 60 days) will incur a 1½% per month finance charge. If the account is referred for collection, the parent or guardian will be responsible for the balance plus any and all related collection costs. Please indicate your payment method:

Cash _____ Check _____ Visa/Mastercard _____ Medicaid _____

If you have dental insurance, please check here ☐ and refer to the back of this form.

CANCELLATION POLICY: We understand that unforeseeable circumstances occur and sometimes require missing an appointment. However, if you do miss an appointment without notifying our office 24 hours before your scheduled appointment it will be considered a broken appointment. After two broken appointments we will no longer be able to provide care for your child. This policy is to protect dental appointment times for your child and other children that need care.

LATE POLICY: Please understand, for a typical 30 minute appointment, tardiness of even 10 minutes can greatly diminish the quality of care your child should receive. Children often need extra TLC and tardiness decreases the team's ability to care for your child in the way he/she deserves. Therefore, if you are late, we may need to reschedule your appointment. Please know that our team will make every effort to see your child as promptly as possible.

Signature _____ Date _____

DENTAL INSURANCE POLICY:

Dental insurance is a very positive benefit for many families and plays a major role in helping individuals obtain good dental care. The primary objective of all types of dental insurance is to aid you by partially paying for certain dental care expenses.

For check-ups, we ask that you pay for our services in full at the appointment. We will submit a claim to your insurance company on your behalf. The insurance company will reimburse you directly. The amount of reimbursement is set by your insurance company.

For restorative visits, including conscious sedation appointments, we will obtain a pre-treatment estimate. This estimate will help determine what portion your insurance company will cover. We ask that you pay your estimated portion at the time services are rendered. Following treatment, a claim will be filed. We will ask the insurance company to reimburse us directly. We will bill you for any difference.

Please remember, your insurance contract is between you and your insurance company. Our involvement is to provide dental care for your child and as a convenience to you, make every effort to help you claim the maximum benefits that your insurance offers. Regardless of your insurance coverage, you have the final and full responsibility of costs incurred at our office.

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file.

I have reviewed the treatment plan. I authorize release of any information relating to this claim.

_____

Signature of patient or parent (if minor)

I hereby authorize payment directly to Harrisonburg Pediatric Dentistry of dental insurance benefit otherwise payable to me.

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Signature of patient or parent (if minor)