Office Policy

Thank you for choosing My Pediatric Dentist as your dental care provider. We are committed to providing you with quality dental care. The following is a statement of our financial policy, which we require you to read, agree and sign prior to any treatment. Please note that full payment is due at the time of treatment and all charges incurred are the patient's responsibility. Regard less of insurance coverage.

INSURANCE: As a courtesy, we file claims on your behalf with your insurance company immediately after treatment. Please note that an insurance policy is a contract between your insurance company and you. If you have any questions regarding coverage, you must contact the insurance company directly. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates unless our office is a preferred provider with your insurance company.

If you are a new patient, please present your insurance card prior to treatment. If we are unable to verify your insurance, full payment is due at the time of treatment. If your insurance has changed, it is your responsibility to update our office with the new information.

Payments: Our office will accept payments in the form of cash, check, Visa, MasterCard, Discover and Care Credit. We do not accept partial payment plans, but we do offer payment plans through Care Credit, some of which are interest free. At the time of treatment the estimated portion is due. After we receive payment from your insurance company, the remaining balance is due in full. Any adult accompanying a minor is responsible for the payment due at the time of service as well as providing us with appropriate insurance information, if applicable. If we do not receive payment from your insurance company within 30 days of submitting your claim, you will be responsible for full payment. If we receive subsequent payment from your insurance company, you will be refunded. Please note that returned check will be subject to additional fees.

Late cancellations/ Missed appointments: We understand that circumstances occur that do not allow you to keep your appointment. In this case, please call us at least 48 hours in advance. If you are more than 15 min. late, we reserve the right to reschedule. Your appointment time is reserved only for you. Please help us serve you better by keeping scheduled appointments or changing it in a timely matter.

- **If two (2) missed appointments occur or two (2) cancellations without 24 hour notice, our office reserves the right to DISMISS.**

Understanding, Authorization and Release: I have read, understood and agreed to all of the terms of My Pediatric Dentist's Financial Policy. I authorize My Pediatric Dentist to release any information; including diagnosis and the records of any treatment or examination rendered by my dependent(s) or me during the period of such dental care to the third party payer or other health practitioners. I authorize and request my insurance company to pay directly to My Pediatric Dentist insurance benefits otherwise payable to me. I agree to be responsible for payment and related charges of all services rendered on my behalf or my dependent(s).

HIPAA Privacy: We thank you for the opportunity to provide you with quality dental care. We respect all of our patients and wish to keep you notified of our policies. My Pediatric Dentist follows HIPAA privacy laws and has a copy of HIPAA regulations available at your request. If we change our privacy practices or financial policy, we will post a copy in our office in a prominent location, have copies of the revised notice at our office and provide you a copy at your request.

This consent will remain active unless withdrawn in writing by the person, who has signed on behalf of the child.

*X:*____________________	*X*____________________	__________
Name(Print)	**Signature**	**Date**

Informed Consent

Dear Parent or Guardian,

Please complete this Informed Consent for your child's appointment.

Patients Name: ______________________________ **Parent (or Guardian) Name:** ______________________________

EXAM and CLEANING

Regular exams and cleanings play an important role in proper dental health. They allow the dentist to screen for dental caries, gingival and/or periodontal issues or orthodontic needs. A cleaning, fluoride treatment, x-rays and exam are performed. Risks include but are not limited to: sensitivity or bleeding of the teeth or gums due to scaling. I understand that if I choose not to maintain regular check-ups and/or cleanings, this decision may result in decay, pain, infection, and/or orthodontic or periodontal problems.

Initial______________

X-RAYS

X-rays are used as an important diagnostic tool for the dentist. How often x-rays are taken depends on the age, risk for disease, and signs and symptoms of the patient. Our office follows the recommended guidelines from the FDA and the American Academy of Pediatric Dentistry. Many diseases of the teeth and surrounding tissues cannot be seen when your dentist examines your mouth visually. An x-ray may reveal the presence of small cavities between the teeth, infections in the bone, abscesses, cysts, developmental abnormalities and some types of tumors. It is in your child's best interest to be periodically screened with the use of diagnostic x-rays. Risks of not taking x-rays include but are not limited to: a failure to diagnose and treat conditions before signs and symptoms have developed than can threaten oral and general health. Risks from radiation exposure have been significantly reduced by improvements in technology. The benefits of dental x-rays to promote adequate and quick diagnosis outweigh the potential adverse effects. I understand if I choose to not allow x-rays to be taken, I may be asked to transfer my child to another dentist.

Initial______________

FLUORIDE TREATMENT

Fluoride is a naturally occurring element that prevents tooth decay systemically when ingested during tooth development and topically when applied to erupted teeth. Topically applied fluoride provides local protection on the tooth surface. Topical fluorides include toothpaste, mouth rinses and professionally applied gels and rinses. In addition to their use in caries prevention, topical fluorides may be used to control established carious lesions. Systemic fluorides are those that are ingested into the body and became incorporated into forming tooth structures. Benefit: Fluoride helps to prevent tooth decay by making teeth stronger. Fluoride can be applied topically, in which case a gel, paste, rinse, or solution is placed on the teeth where fluoride acts directly on the tooth enamel. The application of concentrated fluoride solutions or gels may result in a reduction of dental caries. The alternative is conventional methods of dental caries prevention at home: brush twice daily with fluoride toothpaste, floss and avoid frequent snacking. Fluoride is the most effective caries-prevention agent available today. It is considered safe when properly used. The ingestion of high concentrations can lead to nausea, vomiting, dental fluorosis, which is a chalky white to brown discoloration of the permanent teeth. The complications or overdose may require medical assistance or hospitalization and even death. Consequences of not performing treatment: being deprived of the benefit of topical fluoride application and its property to prevent tooth decay and control the cavities already present.

Initial______________

I understand that dentistry is not an exact science; therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and to ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment during my child's appointment.

Parent or Guardian Signature____ **Date**________________

PEDIATRIC DENTISTRY INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Health professionals have an obligation to provide their prospective patients with information regarding the treatment or procedures they are recommending. Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits and alternatives. Please read this form carefully and ask about anything you do not understand. We will be pleased to further explain it to you.

It is our intent that all professional care delivered in our dental operatories shall be of the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or the sharp dental instruments. Some of these behaviors will be age appropriate for the child and some may not.

All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding.

There are many behavior management techniques used by pediatric dentists and approved by the American Academy of Pediatric Dentists to gain the cooperation of child patients to eliminate or reduce disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The most frequently used pediatric dentistry behavior management techniques used in this office can be summarized as follows:

1. TELL-SHOW-DO: The dentist or assistant explains to the child what is to be done using simple age-appropriate terminology. Secondly, the child is shown the procedure on a model, the finger of the dentist or assistant. Lastly, the procedure is performed for the child as described.
2. POSITIVE REINFORCEMENT: Praise is given to the child in order to reinforce cooperative behavior. Desirable behavior is rewarded with an acknowledgement that the behavior is good.
3. VOICE CONTROL: The attention of a disruptive or uncooperative child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is many times less important than the abrupt, sudden or strict nature of the command.
4. SOLO COMMUNICATION WITH CHILD: The pediatric dentist asks that the parent be an observer at chair-side and let the dentist verbalize with the child one-on-one.
5. MOUTH PROPS: A rubber or similar type device is placed in the child's mouth to prevent closing and possible injury when a child refuses or has difficulty maintaining an open mouth.
6. PROTECTIVE RESTRAINT BY THE DENTIST/DENTAL ASSISTANT, or PARENT: The dentist, assistant, or parent (under direction by the dentist) restrains the child from movement by holding the child's hands, stabilizing the head, and/or controlling leg movements.
7. PHYSICAL RESTRAINT BY THE PARENT: The parent may be asked to help with controlling undesirable movements or just to provide security by holding the child's arms in his/her lap.
8. ADVANCED BEHAVIORAL MANAGEMENT TECHNIQUES; Nitrous Oxide, Pediatric wrap and General Anesthesia (WILL BE DISCUSSED PRIOR TO USAGE)

The listed pediatric dentistry behavior management techniques have been explained to me. Alternative techniques, if any, have also been explained to me, as have the advantages and disadvantages of each. I hereby authorize and direct the dentists at My Pediatric Dentist and dental auxiliaries of their choice, to utilize the behavior management techniques listed on this consent form to assist in the provision of the necessary dental treatment for my child. I hereby acknowledge that I have read and understand this consent, and that all questions about behavior management techniques described have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions, which may arise during the course of my child's treatment. I further understand that this consent shall remain in effect until terminated by me.

X:____________________________ **X**____________________________ __________

Name(Print) **Signature** **Date**