Dream Smiles
Pediatric Dentistry of Gaithersburg

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# OFFICE POLICIES

*Please INITIAL after EVERY section*

## Consent for Services

- ✓ I authorize the doctor or staff to take x-rays, photographs or any other diagnostic aids deemed appropriate by doctor to make thorough diagnosis of patient's dental needs.
- ✓ I authorize the doctor to perform all recommended treatment mutually agreed by me and to use appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent the doctor to choose and employ such assistance as deemed fit to provide recommended treatment.
- ✓ I understand that my insurance is a contract between myself and the insurance company. Dream Smiles Pediatric Dentistry of Gaithersburg is not part of that contract. I do not hold the office responsible for any deductibles, co-payments, covered or non-covered charges, "usual and customary" charges, etc. other than to supply factual information regarding services rendered. If I have any questions or disputes I will contact my insurance company.
- ✓ I have been shown a copy of Dream Smiles Pediatric Dentistry of Gaithersburg's Notice of Privacy Practices and understand I can request a copy.
- ✓ I give consent to obtain, use, and disclose my child's protected medical health information to carry out treatment, payment activity, and healthcare operations.
- ✓ I grant permission for this office to telephone me at home or at my work to discuss matter related to my child.

_____ INITIAL

**SOCIAL MEDIA – Please initial ONE of the two options**

☑ _____ INITIAL YES, I authorize this office to post pictures and videos of my child on social media including, but not limited to, Facebook and Instagram.

**OR**

☒ _____ INITIAL I opt out of having my child's pictures and videos on social media including, but not limited to, Facebook and Instagram. I will notify the staff promptly to ensure my child is properly noted to abstain from social media posts.

## Financial Policy

- ✓ I understand that payment is due at the time of service unless other arrangements have been made in advance in the form of cash, check, VISA, Discover, MasterCard, American Express, or CareCredit.
- ✓ I understand that if there is a balance on my account I may be asked to make a full payment before my child can be seen examined or treatment can be rendered.
- ✓ I understand that my insurance is a contract between myself and the insurance company. I cannot hold *Dream Smiles Pediatric Dentistry of Gaithersburg* responsible for any deductibles, copayments, non-covered charges, "usual and customary" charges, or balances resulting from deductibles, copayments, non-covered charges, "usual and customary" charges, etc.
- ✓ I understand that the *Dream Smiles Pediatric Dentistry of Gaithersburg* accepts most PPO insurances and I am fully aware whether this provider is in- or out-of-network with my insurance company and specific group plan.
- ✓ I understand that if this provider is out-of-network with my insurance company and specific group plan, then I will be charged office fees and will be responsible for office fees incurred for "non-covered services."
- ✓ I understand that if I do not have dental insurance and choose to pay out of pocket, I will pay in full the same day services are rendered.
- ✓ I understand and am aware of my plan coverage, frequencies, and limitations. I will review them annually for any benefit changes or exclusions.

_____ INITIAL

## Guardianship/Responsible Party

- ✓ I am legally a responsible party in bringing my child(ren) to appointments for cleanings, treatments, and examinations.
- ✓ I am financially responsible for dental bills and balances, deductibles, copayments, fees, and charges due.
- ✓ I will notify *Dream Smiles Pediatric Dentistry of Gaithersburg* if anyone other than myself or spouse is accompanying my child(ren). I will fill out a *Guardian Consent Form* for any addition persons that I authorize to make decisions on my child(ren)'s dental treatment or care.
- ✓ I understand that if my child is brought to an appointment without me, all procedures he/she is scheduled for will be done and I will contact the office to decline or add any services.
- ✓ *In cases of divorced and separated families* – Regardless of divorce or separation agreements, in or out of court proceedings, *Dream Smiles Pediatric Dentistry of Gaithersburg* will not get involved in any specific arrangements concerning scheduling or billing. I understand that my divorce or separation agreement is a contract between the two parties who made the agreement.

_____ INITIAL

## Cancellation/Reschedule Policy

- ✓ I understand that my child(ren) will be provided appointment times that are appropriate for their ages and needs.
- ✓ I understand that as a courtesy *Dream Smiles Pediatric Dentistry of Gaithersburg* will send appointment reminders in the form of text, phone call, or email, but it is my responsibility to know my child(ren)'s appointment date and time.
- ✓ I understand that if my appointment has been reserved and it is my responsibility to be at the office on time. If I arrive 15 minutes past the scheduled appointment time I may have to reschedule the appointment or wait until my child(ren) can be seen.
- ✓ I understand that *Dream Smiles Pediatric Dentistry of Gaithersburg* needs at least **48 hour notice for any cancellation or reschedule of any type of appointment**.
- ✓ I understand that if I cancel or reschedule any appointment with **less than 48 hour notice I will be charged $50 per child.**

*We want to give everyone the same amount of time for their dental care by meeting their scheduled appointment time. Our staff strives to respect your time and do our part to care for your child in a timely manner. We understand that circumstances occur that may not allow your child to make a scheduled appointment. Nevertheless, we ask for sufficient notice before a missed appointment, whether 48 hours or less. Exceptions and fee waivers will kindly be determined upon the discretion of our front office staff.*

_____ INITIAL

*I have read the above conditions of treatment and payment and agree to their content.*

| _____ | _____ | _____ |
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| **Patient Name(s)** | **Parent or Guardian Signature** | **Date** |