Pacific Pediatric Dentistry

Patient Acknowledgements

We are committed to providing you with the best possible care and helping achieve your child's optimum oral health. Toward the goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: cash, check, credit card, and care credit. The parent that accompanies the minor child/children to the appointment is responsible for any payment due. Checks returned to our office from your financial institution are subjected to a **$30.00 fee.**

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. In the event we do accept assignment of benefits and dental benefits are not paid in full within 60 days of treatment, the expected insurance balance will become your responsibility. ***We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance within the management of your account.*

Cancellation Policy: The appointment schedule is maintained to respect the time and convenience of our patients, as well as their emergency needs. Prompt arrival is greatly appreciated. If you are 15 or more minutes late, your appointment will be at risk of being rescheduled. No charge is accrued for broken appointments prior to 2 business days in advance**. If failed to give notice 2 business days prior, there will be a $50 charge for a broken appointment of a recall, a $75 charge for a restoration appointment, and $100 charge for an oral conscious sedation appointment.**
_____(Initials)

Patient Communication: I consent to receiving appointment reminders via unencrypted email or text. I consent to the dental practice using my cell phone number regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw consent at any time.
_____(Initials)
I have read the above and agree to the financial and scheduling terms._____(Initials)

Authorization Release: I hereby authorize the release of information necessary to process my dental benefit claims, the use of my signature on all insurance submissions, and authorize my insurance benefits to be paid directly to Pacific Pediatric Dentistry._____(Initials)
I hereby authorize doctor or designated staff to take x-rays, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my child's dental needs._____(Initials)

Acknowledgement of receipt of Dental Materials Fact Sheet: *I acknowledge that I have been offered a copy of the Dental Materials fact Sheet.*

_____
Patient/Parent/Guardian Signature(Circle) Date

Acknowledgement of receipt of Notice of Privacy Practices: *We are required to provide you with a copy of our Notice of Privacy Practices. Please sign below to acknowledge receipt of this notice.*

_____
Patient/Parent/Guardian Signature(Circle) Date

_____
Patient(s) Name Witness Date