SAN DIEGO PEDIATRIC DENTAL & ORTHODONTIC GROUPS

Office Policy and Information

Name of person completing this form:_____ Relationship to patient:_____

Please specify your preferred method of contact. _____

Appointment Policy- A parent or legal guardian must accompany the child to all appointments. If this is not possible you must inform our office prior to the appointment and request an additional consent form for the authorized adult who will be attending with your child. Unlike many other pediatric dental offices, we welcome parents and siblings to our treatment area so they can sit with their child during cleaning appointments. Because of limited space, one parent is allowed to accompany child for operative appointments.
Parents are not permitted in the treatment rooms during monitored anesthesia care (Deep Sedation) appointments appointments. **Initials**_____

Cancellation Policy- We greatly appreciate your efforts in honoring scheduled appointments and wish to provide all of our patients with the highest quality dental care in the most reasonable time possible. Please notify us 48 hours prior to your scheduled appointment if you will be unable to make it. If a patient fails or cancels two (2) scheduled appointments without 48 hours advanced notice, we will institute a broken appointment fee of $50. The fee will increase by $25 per child for each subsequent cancellation or reschedule without 24 hour notice. The fee must be settled prior to scheduling any future appointments. If you arrive more than 10 minutes after the scheduled start time for your appointment you may be asked to reschedule. **Initials**_____

Payment Policy- We accept Visa, Mastercard, Discover, Amex, Care Credit, Checks, and Cash to settle your portion. Patient portion and all copays are due in full on the day services are rendered. Please be aware that the parent or guardian bringing the child to Kensington Pediatric Dentistry is legally responsible for payment of all charges. We cannot send statements to other persons. Accounts with past due or unpaid balances cannot schedule additional appointments until balance is paid in full. **Initials** _____

Insurance Policy- To alleviate our patients' concerns about costs of treatment, our office verifies insurance benefits online or over the phone prior to the first appointment. Upon verification we can determine eligibility and basic coverage details. We MAY NOT have access to contracted fees specific to your group plan. Please understand that we can only provide an estimate of how much your insurance might pay towards any treatment.

*A pre-authorization can be submitted at your request, but will delay treatment by approximately 6 weeks.
*Benefits quoted to our office over the phone and online verifications are not a guarantee of payment.
*Benefits are determined upon claim submission.
*If we do not receive payment from your insurance company within 6 weeks after submission of a claim you will be expected to pay for dental services in full.
*We cannot bill any HMO or managed care plans for services rendered at our office - we are still happy to see you.
*You must complete and sign a HIPAA form if you wish to have our office file insurance claims on your behalf. Copies of the Health Insurance Portability and Accountability Act are available upon request.

In order to file insurance claims we need the following information.

Policy holders name & date of birth:_____ ____/____/_____ Relationship to patient_____

Insurance carrier/company_____ Policy holders insurance ID # or SSN_____

Please inform our office of any insurance changes at least 2 business days prior to your child's next appointment. We can not guarantee same day eligibility verification. Payment is due in full unless eligibility is verified by our office.
Initials _____
We take a picture of all our patients for their confidential file. **Initials** _____