CARSON CITY PEDIATRIC DENTISTRY

OFFICE and APPOINTMENT POLICY

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide your child/children with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- FULL CO-PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS CREDIT CARDS, AND DEBIT CARDS. WE ALSO OFFER CARE CREDIT WHICH IS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.
- For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- **For patients with Dental Insurance**:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
  We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy. All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- **Usual and Customary Rates** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- **Payment Plans** Carson City Pediatric Dentistry has partnered with Care Credit, a patient financing company, to offer our patients 0% interest financing for 3, 6, or 12 months with approval. No other payment plans are available.

OFFICE POLICIES

- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- **CHECK POLICY:** Any NSF or stop payments placed on a check will be assessed a fee of $35.00.
- **LATE FEE:** We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- **PAST DUE ACCOUNTS:** if your account becomes past due we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of balance to a lawyer you agree to pay all lawyers' fees that we incur plus all court costs.
- **Collections** Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and once you are on collections you will be dismissed from the practice.
- **Waiver of Confidentiality:** you understand that this account will become a matter of public record if we submit to an attorney or collection agency, or if we have to litigate in court.

APPOINTMENT POLICY

Carson City Pediatric Dentistry is dedicated to quality dental care for your child and is pleased to reserve an appointment time exclusively for them. Because we reserve time exclusively for each patient, we ask that you make every effort to not change your reserved dental appointment. If you find that you cannot keep your scheduled appointment, we require a 48 hour notification. Exemptions can be made for unforeseen emergencies. This allows your reserved time to become available for other patients in need of treatment. In order to make provision, as well as to maintain the most efficient schedule for all our patients, our Appointment Policy is as follows:

• As a courtesy, our lighthouse systems notifies you of your upcoming appointment 1 week in advance, then our staff attempts to confirm appointments 3 days before the scheduled date and time. If we do not hear back from you within 48 hours of your appointment, the reserved time will be cancelled and given to the next patient in need of treatment.

• We request a minimum of a 48-hour notice if you need to cancel or change your scheduled appointment. If we do not receive a 48-hour notice, we reserve the right to charge an $80 fee to your account, at our discretion. If two or more appointments are broken or missed without the required 48-hour notice, we reserve the right to refuse to schedule future appointments for you or dismissed you from the practice.

• Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day.

• Since we care for children, it is not possible to give everyone appointments in the late afternoon. We like to reserve these times for children six years and older. Generally children under age five are in a better frame of mind and have a more positive experience in the morning, and it's our preference to see children requiring long appointment procedures in the morning. In this way, we can be fair to our many patients who require shorter procedures by offering them more available times in the afternoons when the school day is over. We will gladly provide your child with a school excuse.

• Because late afternoon appointments are in high demand, our last treatment appointment of the day will be at 2:30pm for an 1 hour appointment or 3pm for a 30 minute appointment. We will also be alternating appointments; if you had an afternoon appointment then your next appointment will be in the morning. This gives an opportunity for all patients to schedule an afternoon appointment

I have thoroughly read the Financial and Appointment Policy. I understand and agree to this Policy.

Patient Name: _____ DOB _____

Patient Name: _____ DOB _____

Patient Name: _____ DOB _____

Parent /Legal Guardian Name _____

Signature_____**Date**_____