FINANCIAL POLICY

At our office, we plan to work together to achieve one common goal and that is for our kids to grow up feeling confident about their smiles. We promise to properly communicate all that is needed to obtain that goal, including our financial policy.

Payment in full for office visits and treatment is expected at the time service is rendered. Patients with dental insurance must provide our office with accurate dental insurance information in advance.

INSURANCE

For In-Network Insurances: Our office can file with most major PPO Insurances. If any balance remains after the insurance has paid, a statement will be sent to you requesting that you pay the remaining balance.

For Out of Network Insurances: In the event that our office is not a provider for your dental insurance, we will collect payment in full for the services before they are rendered. We will then file the claim(s) as an out-of-network provider for you and have the insurance benefits assigned to you. Your insurance company should then send you reimbursement for the portion they have agreed to cover in their contract with you/the policy holder.

By signing this form, I am authorizing assignment of benefits and payment from my child's dental insurance directly to Lisa Ameer, D.M.D. I also am authorizing Dr. Lisa Ameer to furnish my insurance company with any and all information that may be contained in my child's medical and dental records that relates to procedures performed in the office of Dr. Lisa Ameer. Again, most insurance companies do not tell us EXACTLY what they will pay, so we are giving you our best estimate.

TREATMENT PLANS

Prior to beginning and completing any restorative treatment, we will provide you with the best cost estimate of our total fee, your estimated insurance coverage, and your estimated out-of-pocket fees. Please remember, these are only estimates and may change during the course of treatment. In order to provide your child with the best treatment option, changes in treatment plans may occur. You will be notified prior to any treatment plan modification along with any fee change incurred.

For your convenience, we accept cash, personal checks for payment under $200.00, debit cards, and most major credit cards. If a check is returned for insufficient funds, a $35 charge will be applied to your account. We cannot accept responsibility for negotiating a disputed claim and allow a maximum of 30 days from time service is rendered for your insurance company to clear account balances. If your insurance company does not pay within 30 days from the date service is rendered, you will be responsible for full payment. A late fee of $15 will be charged per month to unpaid balances over 45 days past due. If after 90 days from the date of service and attempts have been made to collect any outstanding balances, parents/legal guardians not fulfilling their financial obligation will be sent to collections.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all cost, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Any questions you have may be directed to our office and we will be happy to assist you! We are looking forward to beginning a wonderful relationship with you and your child.

I have read and understand the above financial policy set forth by Palm Beach Children's Dentistry and agree to be held responsible for the terms and conditions mentioned above.

Signature of parent/ legal guardian _____ Date_____

Print Name_____ Relationship to patient_____

Patient's Name _____

Palm Beach CHILDREN'S DENTISTRY
DR. LISA AMEER, PEDIATRIC DENTIST

APPOINTMENT POLICY

Palm Beach Children's Dentistry strives to offer an intimate office setting to all of our patients. When we schedule your family for an appointment, we make sure that you get the attention and treatment you deserve from our staff and try to individualize our time with your child.

We take great care to confirm your appointments:
- We implement a text and emailing system using the information you provide on your child's new patient documents.
- This is a good time to let us know if your scheduling needs or insurance information has changed.
- Two(2) days prior to the appointment a text or email will be sent. If you do NOT respond to the text or email, our office will call to confirm the appointment the day before.

Our office requires 2 business days notice of an appointment that needs to be rescheduled. We understand unforeseen circumstances occur and will be glad to extend flexibility at our discretion.

Appointment Policy:
-The **1st time** an appointment is missed or rescheduled less than 2 business days in advance,
- we will make a note on your account and remind you of our appointment policy
-The **2nd time** an appointment is missed or rescheduled less than 2 business days in advance,
- an appointment deposit fee will be incurred to reschedule the appointment. This is considered as a deposit for the time we have allotted for your child to receive quality care.

Appointment Deposit:
Appointment deposits are taken over the phone with Visa, MasterCard, AMEX, and Discover.
If an appointment deposit has been made for the 2nd time of rescheduling an appointment and the appointment is kept, then the deposit is credited to your account. If the credit remains after 90 days and all insurance claims are settled, then a refund check will be issued to you.

If an appointment deposit has been made for the 2nd time of rescheduling an appointment and the appointment is again missed or rescheduled without 2 business days prior notice, your deposit is forfeited and another appointment deposit will be required to schedule any future appointments for your child.

Deposit Fees:
For a Recall/Check-up appointment, the reschedule deposit fee is $30
For a New Patient appointment, the reschedule deposit fee is $30
For ALL Treatment appointments, the deposit fee is $65. If appointment is cancelled without 24 hour notice on 1 occasions, you will automatically forfeit $35 from the initial deposit and be required to pay an additional $35 to bring deposit back to the required $65 total deposit amount.

Palm Beach Children's Dentistry reserves the right to dismiss any family from the practice who abuses our appointment policy.
We thank you in advance for your understanding and cooperation.
I HAVE READ AND UNDERSTAND ALL OF THE PALM BEACH CHILDREN'S DENTISTRY APPOINTMENT POLICY.

Sign _____ **Date** _____ **Relation to Patient** _____

Print Name _____ **Patient Name** _____

Palm Beach Children's Dentistry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Revised October 2013

You may refuse to sign this acknowledgment.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Palm Beach Children's Dentistry. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____ _____

Parent/Guardian printed name Relationship to Patient

_____ _____

Parent/Guardian signature Date

_____

Patient's Name

If you have any questions about this form or the attached Notice, please contact our Privacy Official, Dr. Lisa Ameer.

Office Use Only

As Privacy Official, I attempted to obtain the parent/guardian signature on this Acknowledgment but did not because:

It was emergency treatment	____
I could not communicate with the patient	____
The patient refused to sign	____
The patient was unable to sign because _____	____

_____

Signature of privacy official

Palm Beach Children's Dentistry

CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

I, _____ hereby authorize Palm Beach Children's Dentistry to use and disclose the entire medical record concerning Patient in accordance with the attached Notice of Privacy Practices (NOPP). I have received a copy of and reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release and hold Practice, its employees and agents harmless from any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

_____ _____

Parent/Guardian printed name Relationship to Patient

_____ _____

Parent/Guardian signature Date

_____

Patient's Name