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

FINANCIAL POLICY

Our goal is 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 and any calculated copays for visits are required at the time service is rendered.

For your convenience we accept cash, debit cards and most major credit cards;
we no longer accept checks or American Express.

INSURANCE

Families with dental insurance must provide our office with accurate dental insurance information **at least 2 business days prior** to their scheduled dental appointment, to avoid paying out of pocket. If we have received all of your insurance information prior to your child's visit, we will gladly file your claim for you.

Please understand that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles claims or for what benefits they pay on a claim. We at no time guarantee that your insurance will pay. We do our best to provide accurate estimated copays but it is ultimately your responsibility to be familiar with your dental benefits.

- **In Network:** We are in network with MOST major PPO Insurance companies. To verify that we are in network with your policy, please contact your insurance.
- **Out of Network:** We will collect payment in full at the time services are rendered and will file a claim(s) as an out of network provider for you. The insurance benefits will be assigned to you and your insurance company should send you reimbursement for the portion they have agreed to cover in their contract with you/the policy holder.

By law, your insurance is required to pay each claim within 30 days of receipt. You are responsible for any balance on your account after your insurance has paid. We cannot accept responsibility for negotiating a disputed claim. We 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 $15.00** will be charged per month to any unpaid balance over 30 days past due. If after 90 days and attempts have been made to collect an outstanding balance, parents/legal guardians not fulfilling their financial obligation will be sent to collections and you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33.3% of the debt plus all cost and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

TREATMENT PLANS

Prior to starting and completing any restorative treatment, we will provide you with our best out of pocket estimate based off of your insurance coverage. Per your insurance, fees may change at any time 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.

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!

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. as well as authorizing the office of Dr. Lisa Ameer to furnish my insurance company with any/all information that may be contained in my child's medical/dental records that relates to procedures performed in the office of Dr. Lisa Ameer. 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.

Parent/Legal Guardian Printed Name: _____ Date: _____

Parent/Legal Guardian Signature:_____ Relationship to Patient: _____

Patient Name(s): _____

Palm Beach CHILDREN'S DENTISTRY
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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 your child's 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, 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 $35
For a New Patient appointment, the reschedule deposit fee is $35
For ALL Treatment appointments, the deposit fee is $65. If appointment is cancelled without 24 hour notice on 1 occasion, 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.

Parent/Guardian Printed name_____ Relationship to Patient_____

Parent/Guardian Signature _____ Date_____

Patient's Name(s)_____ _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/USE AND DISCLOSURE

You may refuse to sign this acknowledgement form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you, your child/children and your family account. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). You may review the Notice of Privacy Practices (NOPP) before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available. You have the right to request that we restrict how PHI about you, your child/children and your family account is used or disclosed. Please note that we will not disclose any information that is not medically necessary.

By signing this form, you acknowledge the following: That our practice may use and disclose PHI about you, your child/children and your family account for treatment, payment, referrals to other providers, insurance related and any other healthcare related operations; You have received a copy of the currently effective NOPP for Palm Beach Children's Dentistry (a copy of this signed, dated acknowledgement shall be as effective as the original); You have been given the opportunity to ask questions and you understand and hereby do agree to the terms of the NOPP and this form; You release and hold Palm Beach Children's Dentistry and all agents blameless from any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

_____ _____

Patient Name **Patient's Date of Birth**

_____ _____

Printed Name of Parent/Legal Guardian **Relationship to the Patient**

_____ _____

Signature of Parent/Legal Guardian **Date**

Consent to email/text for appointment reminders and healthcare related communication:

We may contact you via email & text messaging to remind you of appointments & provide general healthcare information. I understand that if I consent to receive communications via text/email, I still have the right to revoke the consent at any

The cell phone # I authorize to receive text messages for is: _____ Initial_____

The email address I authorize to receive messages for is: _____ Initial_____

Only initial if applies: ***I decline*** *to receive communications via text.* _____ ***I decline*** *to receive communication via email.* _____

Revocation – ONLY use this area to document revocation of a specific form of communication

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.

_____ I hereby revoke my request to receive future appointment reminders and healthcare information updates via email.

Name of Parent/Legal Guardian _____ Date Requested: _____

Signature of Parent/Legal Guardian _____