Financial Policy

Thank you for choosing us as your dental provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to your treatment.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND CARE CREDIT.**

Insurance

We require all deductibles and co-pays be paid at the time of service. The balance is your responsibility regardless of whether or not your insurance company pays for your claim. We must have the correct insurance information in order for us to bill your insurance company. We are a 3rd party to the contract. We file claims to your insurance as a courtesy to you. It's ultimately your responsibility to know and understand your dental insurance. IE: Coverages, Maximums and Frequencies; including deductibles. If your insurance company has not paid your account within 60 days, the balance becomes your responsibility. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.

Usual and Customary Rates

Our practice is committed to providing the best possible care to our patients. Our fees are based on what is usual and customary for our area. You are responsible for payment regardless of insurance company's arbitrary determination of usual and customary rates.

Unique Family Situations

We will be happy to submit to either parent's insurance, however, it is our office policy that the parent who brings the child in for their appointment is responsible for any co-pays and the balance on the account.

Missed Appointments

We may apply a missed appointment fee for any missed appointments. We have set that time aside to serve our patients dental needs. We ask you respect that time by keeping scheduled appointments.

Waver of Confidentiality

You understand that if this account is submitted to an attorney or collection agency, if taken to court, or if your past due status is reported to a credit reporting agency, your treatment at our office may become a matter of public record.

**THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.**

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY:

X ___________________________ Date ___________________________
**Broken Appointment Policy**

We have more patients who need dental care than we have room in our daily schedule to provide. We currently have a 4-6 week waiting period for treatment appointments. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are not able to fill this appointment with another patient who desperately needs dental care. In addition, if a patient shows up 10 or more minutes late to an appointment, we fall behind and other patients have to wait. This policy is our attempt to ensure that all patients receive dental care in a timely manner.

**Broken Appointments**: Patients are only allowed **two** broken appointments in a 12 month period.

- A **$35.00 fee will be placed on your account for any no show appointments or cancelled/rescheduled appointments within 48 business hours**.
- Broken appointments are any time you are scheduled for an appointment and you do not show for that appointment.
- Late cancellations are considered broken appointments. If you need to cancel your appointment, we ask that you please call us at least 48 hours before your appointment time.
- Late arrivals are also considered broken appointments. If you do not arrive within 10 minutes of the start time of your appointment, it may be given to another patient.

**Appointment Confirmation**: You must call or text us back to confirm your appointment at least the business day BEFORE your appointment. Our practice closes at 5pm (some Wednesdays in the summer we close at 2:30pm) and we are open 9am-1pm on Fridays. If you do not confirm at least 24 hours prior to your appointment, we may give your appointment away to a patient that is in pain. This will be considered a broken appointment.

If a patient misses their appointment or cancels late for a **third time** within a 12 month period, they will not be **scheduled** another appointment. These patients are still welcome to receive their dental care from us on a “same day appointment” basis. We will place you on our same day call list and call you when we have an opening or cancellation. Moreover, these patients may come to our clinic as a “walk-in patient”. We always do our best to work our walk-in patients into the schedule as long as it does not interfere with the care of previously scheduled patients. Please understand there is no guarantee that you will receive an appointment as a walk-in.

_X_

Signature of Parent or Guardian/Date
**HIPAA PATIENT ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES, CONSENT, AUTHORIZATION AND RECORDS RELEASE FORM**

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices WHICH CAN BE FOUND IN A HARD BOUND BOOK IN OUR RECEPTION/WAITING ROOM for this healthcare facility. A copy of this signed dated document shall be effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI (protected health information) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OF RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR OR FACILITIES IN THE FUTURE.**

Please PRINT name of PATIENT (s)

Please PRINT name of PATIENT (s)

Please PRINT name of PATIENT (s)

Please PRINT name of PATIENT (s)

PRINT name Parent/Guardian

Relationship to patient(s)

Please list any other parties who can have access to your health information: (this includes step-parents, grandparents and caretakers who can have access to patient’s records)

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

I AUTHORIZE CORRESPONDENCE FROM THIS OFFICE TO CONFIRM MY CHILD/CHILDREN(S) APPOINTMENTS, TREATMENT/HEALTH INFORMATION, AND BILLING INFORMATION, VIA:

Cell Phone Confirmation
Home Phone Confirmation
Work Phone Confirmation

Text Message - Cell Phone
Mail
Email Confirmation

__________________________________________  ______________________________
Signature of patient or parent/guardian          Date
Designation of Another Person to Consent for Dental Care

It is best that a parent or legal guardian accompanies children for each visit to PedZ Dental. However, we understand there may be times when someone other than you takes care of your child. If your child must be seen at these times, we require a signed consent to provide any and all dental care.

This consent form allows the person you choose to seek dental treatment and sign consent for your child when you are unable to come with the child.

- The person you name must be greater than 18 years of age.
- Please use a separate form for each child if more than one.

I, __________________________, cannot accompany my child, _____________ to PedZ Dental. Therefore, I am giving permission to __________________________.

- I give permission for this person to seek dental treatment for my child. This permission includes: exam, x-rays, prophylaxis (cleaning), fluoride treatment, restorative treatment (fillings, pulpotomy, etc), Nitrous Oxide (happy air), and any other dental treatment deemed necessary by Dr. Stacey Zaikoski and her team. This consent shall remain in effect until cancelled by the parent or guardian in writing.

Parent/Guardian Signature: X

Phone Number: ____________________________________________________________

Date: ____________________________________________________________
CONSENT FOR NITROUS OXIDE
“HAPPY AIR”

Nitrous Oxide (N2O) is an odorless, tasteless gas often used in medical and dental procedures to decrease anxiety. Most commonly nitrous oxide is breathed in through the nose. When used alone, (with no other drug or medicine), it is considered an anxiolytic (decreases anxiety), not a sedative. Most children/adults do not fall asleep while breathing in nitrous oxide. Rather, most report feeling “floaty” and relaxed. Nitrous oxide takes 3-5 minutes to take effect, and at the end of the case, the nitrous oxide is turned off and replaced by 100% oxygen for 3-5 minutes. The effect of nitrous oxide lasts for about 5 minutes after treatment has ended. For routine fillings, children can return to school/daycare with no restrictions unless directed differently by your dentist.

Children who are sick and/or congested may be rescheduled to a later date. Children/adults who have received Bleomycin Sulfate (chemotherapy drug), had recent head trauma, have COPD, or who are pregnant should NOT receive nitrous oxide/oxygen.

Please be advised we will collect $74 for nitrous oxide (happy air) at the time of service for appointments of 75 minutes or less. We will collect $150 for nitrous oxide (happy air) at time of service for appointments longer than 75 minutes. We will still bill to your insurance for this service. However, this is usually not a covered service. If you happen to have an insurance that covers the nitrous we will reimburse you.

I have disclosed my child’s current medical conditions, medications, and allergies to Dr. Stacey Zaikoski. We have reviewed treatment risks, benefits and alternatives. All questions have been answered. I give consent for Dr. Stacey Zaikoski and the staff at PedZ Dental to administer nitrous oxide for my child.

Patient Name: ____________________________________________________________

Parent/Legal Guardian Printed Name: ________________________________________

Parent/Legal Guardian Signature: X__________________________________________

Date: ____________________________________________________________________
PATIENT INFORMATION (These questions are of great value to us in caring for the individual needs of your child.)

Name _______________________________ Nickname _______________________________

Age ____________________________ Place of birth (city) ____________________________

Please Circle: Male Female

Approximate: Weight __________________________ Height _______Ft. _______in.

DENTAL HISTORY

A. Date of last dental care __________ Where? ______________ Treatment? ______________

B. Purpose of today's visit, present complaints ____________________________

C. Do you think your child is very nervous or fearful about today's visit? ______________

D. How was patient's behavior and cooperation at previous dental visits? ______________

E. Does patient do well with toothbrushing and oral hygiene? ______________

F. Is there fluoride in your water? ______ Are fluoride supplements taken? ______ School rinses? ______

G. Any oral habits? ________ Pacifier? ________ Does patient presently nurse or use a bottle? ______

H. Is there any history of trauma or accidents to the teeth or mouth? ______________

I. Does the patient grind their teeth at night? ________ TMJ/joint problems? ________ Related headaches? ______

J. Has any member of your family been treated in this office? ______________ Family Dentist ______

K. Who referred you to our office? ______________ Family Dental Office ______

GENERAL INFORMATION (parents)

A. (Mr.) Name __________________________ Phone __________________________

Home Address __________________________ City, Zip __________________________

Occupation __________________________ Employed By __________________________ Cell Phone __________________________

Social Security Number __________________________ Date of Birth __________________________ Marital Status __________________________

B. (Mrs., Miss, Ms.) Name __________________________ Phone __________________________

Home Address __________________________ City, Zip __________________________

Occupation __________________________ Employed By __________________________ Cell Phone __________________________

Social Security Number __________________________ Date of Birth __________________________ Marital Status __________________________

C. Do You Have Dental Insurance? ______________ If yes, please answer section D. below.

Policy Holders Name __________________________ Birthdate __________________________

D. 1st Insurance Co. __________________________ 1st Insurance Co. Address __________________________

Group # __________________________ Employee ID __________________________ Ins. Phone # __________________________

2nd Insurance Co. __________________________ 2nd Insurance Co. Address __________________________

Group # __________________________ Employee ID __________________________ Ins. Phone # __________________________

E. Email Address __________________________

GENERAL CONSENT FOR PEDIATRIC DENTAL CARE

I hereby authorize and request the performance of dental services on the above names patient by the professional dental staff of PedZ Dental. This professional staff includes dentists (named at the top of this form) who are pediatric dentistry specialists, dental hygienists, and trained dental assistants. I understand that this practice specializes in the treatment of children, adolescents, and handicapped patients. I agree to be responsible for the charges for such dental services as performed on the above named patient. I am aware that the parent bringing the child for dental care is legally responsible for payment of all fees.

Signature of Parent or Guardian __________________________

Relationship to Patient __________________________
MEDICAL HISTORY

Patient Name ____________________________ Birthdate ____________________________

A. Family physician or pediatrician ____________________________ Address ____________________________

B. Approximate date of last physical exam ____________________________

C. Current treatment being provided by physician ____________________________

D. Current medication being taken by patient ____________________________

E. Any previous hospitalization? __________________________________________

F. Present or past history of significant bacterial or viral infections __________________________________________

G. Is patient allergic to anything? ____________________________ What? ____________________________

H. Have there been any abnormal reactions to drugs? ____________________________

I. Does the patient have any history of:

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<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Heart condition</td>
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<td>Diabetes</td>
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<td>Asthma</td>
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<td>Abnormal Bleeding</td>
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<td>Blood Transfusions</td>
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<td>Kidney Disease</td>
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<td>Liver Disease</td>
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<td>Breathing/Lung Problems</td>
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<td>Hearing/eight Abnormalities</td>
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<td>Cancer/Blood Discrasias</td>
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<td>Headaches</td>
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<td>Congenital Birth Defects</td>
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<td>Seizures</td>
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<td>Behavioral/Learning Problems</td>
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<tr>
<td>HIV/AIDS</td>
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</tbody>
</table>

Please write details about any medical problems marked YES above.

______________________________________________________________________________

______________________________________________________________________________

Is there any other significant medical problem that we should know about?

______________________________________________________________________________

______________________________________________________________________________

Signature of Parent or Guardian ____________________________

Relationship to Patient ____________________________