

FINANCIAL POLICIES, OFFICE POLICIES, AND AUTHORIZATION FOR SERVICES

Financial Policies:

The adult accompanying the dependent to the dental appointment is financially responsible for the services provided that day.

Any fee for services provided, insurance deductible, copay, and any other fee not paid by your insurance company, is to be paid in-full on or before the day of services provided.

All emergency dental services, or any dental services performed without previous financial or insurance arrangements, must be paid for at the time services are performed.

Any fee estimate is only valid for a period of 3 months from the date of the patient examination.

Accepted Forms of Payment: Visa, MasterCard, Cash, and CareCredit (limitation applies). **No checks accepted.**



Policies for No Show, Late Arrival, Rescheduling, or Canceling Appointment (\$50 fee or dismissal from practice):

Your child's appointment time is **reserved** specially for him or her. All reasonable effort will be made to confirm the appointment with you. ****If you (one of the following occurs): (1) failed to show, (2) arrived more than 20 minutes late, (3) canceled, or (4) rescheduled the reserved time, it will be considered a "Missed Appointment". After two such "Missed Appointments", may result in a \$50 fee per patient per missed appointment on your account or regrettably the dismissal from our practice.**



Photo and Video Policies:

Videography is forbidden anywhere in our office. Please **do not take photographs in our office without expressed consent from our doctor and staff.** If you wish to have a memento of your child's visit, **please ask** one of our team member for help.

We will be happy to take a photograph for you and your child.



Other Office Policies:

Parent or legal guardian must be present in the office during patient's appointments.

For the safety of patients, staff, and doctors, non-concealed video surveillance is used in Corona Kids Dental. Video data is secured with reasonable efforts for your privacy. In certain circumstances, we may share the data with the police, and/or other entities required by law.

Authorization for Service:

I authorize the diagnosis of my child's dental health by means of comprehensive examination, digital radiograph, study models, clinical photograph, or other diagnostic aids deemed appropriate. I also authorize aforementioned diagnostic materials may be used for purposes of professional consultations, research, education or publication in professional journals. I further authorize any recommended dental cleaning and topical fluoride treatment.

In the event of medical emergency, I authorize doctors and staff of Corona Kids Dental to provide emergency medical care and to take appropriate measures, including contacting the Emergency Medical Services (EMS) system and arranging for transportation to the nearest emergency medical facility.

I authorize Corona Kids Dental to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners, for purposes of facilitating care and/or obtaining reimbursement. I understand that once released, doctor and Corona Kids Dental have no responsibility for any further release by the individual receiving this information.

I authorize the payment from my insurance carrier to submit payment directly to the dentist or Corona Kids Dental to be applied directly to any outstanding balance on my or my child's account.

Your children's (dependents') names:

1.	<input type="text"/>	<input type="text"/>	3.	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	4.	<input type="text"/>	<input type="text"/>
	First Name	Last Name		First Name	Last Name

I, the undersigned, hereby certify that I have read and understood all of the above financial and office policies. I will abide by the terms and consequences of this agreement, and is giving authorization for services for my dependent(s).

Signature of **Parent**, or Legal guardian:

<input type="text"/>	<input type="text"/>	X _____	<input type="text"/> / <input type="text"/> / <input type="text"/>	_____
Print name	Relation to patient	Signature	Date (mm/dd/yyyy)	Staff