



# *Camino Pediatric Dentistry Office Guidelines*

## ***WELCOME***

Welcome to our practice. Please review our Guidelines briefly explained below. If you have any questions, please do not hesitate to ask us to clarify.

### ***SCHEDULING AND CANCELING APPOINTMENTS***

We generally schedule appointments for your convenience. However for young children, to ensure they have the best experience possible, we typically insist on seeing them in the morning when they are freshest. Please note that for children in school, dental appointments are excused absences, and we will be happy to provide documentation of dental appointment.

If you ever need to cancel or reschedule, we ask you to please give us at least a two-day notice. With sufficient time, we can release the time we have reserved exclusively for you to our other patients.

### ***STAYING WITH YOUR CHILD***

We generally encourage parents to come to the back with their children. Having parents with us in the back allow us to better explain the procedures and answer parents' questions. However, if parents insist, they may stay up front and be requested to come to the back on an as needed basis.

### ***FINANCIAL GUIDELINES***

1. All professional fees are due at the time of service.
2. Our office is considered **out of network** with ALL dental insurance companies.
3. For patients with insurance:
  - a. Co-payments and deductibles are due at the time of service.
  - b. After 30 days, all outstanding balances, including outstanding insurance claims, are due and payable by you.
  - c. As a courtesy we bill your insurance on your behalf. It is not our responsibility or obligation to bill. The insurance company sees you as customers, and us only as third parties. Help us be effective by being understanding and cooperative throughout the process.
  - d. We recommend that you keep track of your benefits (such as maximums or eligibility requirements) and to call the insurance company directly whenever you have questions.
  - e. Failure of your insurance to pay does not indicate that the treatments were not important or that we should waive our fees.
4. We reserve the right to charge a cancellation fee for failure to give 48 hours notice to reschedule or cancel appointments.
5. Parents or guardians must accompany the child at time of treatment or submit written treatment and financial consent at each and every visit.
6. There is a \$30.00 fee for all returned checks.
7. We strive to inform all patients of the fees relating to all treatments planned. However, if parents have questions about any of the proposed procedures, it is also their responsibility to inquire before the treatments start.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### ***ASSIGNMENT OF INSURANCE BENEFITS***

I hereby authorize payment directly to *CAMINO PEDIATRIC DENTISTRY* for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_