NOTICE OF PRIVACY PRACTICES, TREATMENT CONSENT AND OFFICE POLICIES

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OFFICE POLICIES (Updated 1/09)

1) Payment is due at the time of service.
2) As a courtesy to our families we will check your dental benefits and submit claims for patients. Please note that this is a courtesy and that we are only estimating your financial obligation. It is ultimately the responsibility of the policy holder to know and understand their own policy. Financial responsibility for any service not covered is the parent's/guardian's.
3) For patients with insurance, only the estimated portion that insurance will not cover is due. Again, please note that this is only an estimate and the actual amount owed may be more or less.
4) We kindly request at least one business day (24 hours) notice for cancellations. Please note that for Monday appointments this requires a change/cancellation by or before Friday.
5) Cancellation with less than one business day notice may incur a $50 cancellation fee.
6) We reserve a specific block of time for each patient to allow the proper amount of time to care for each child. Therefore if you arrive late for an appointment your child may not be able to be seen and you may be assessed our cancellation fee.
7) Professional fluoride treatments are a central component of our preventative approach. These treatments will be completed at each of your child's cleaning appointments. Please note that some dental insurance plans only cover these treatments one time per year. If you would like our office to skip these recommended treatments we require written notice before your child's appointment. Initial__________

PERMIT FOR TREATMENT UPON A MINOR

The information I have given on the medical history form is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status.
I, being the parent or guardian of the above minor patient, do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of any operation or treatment.
I authorize the administration of anesthetics or analgesics which may be deemed advisable by the Doctor. Furthermore, I understand as the parent or guardian who accompanies the child I will be responsible for all financial obligations incurred on this child for dental treatment.
I give my permission to use these records for consultations and educational purposes.

Initial__________

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received and reviewed a copy of Dr. Berman's Notice of Privacy Practices. I also acknowledge I have read the above and give consent to treatment as well as agree to all office policies.

Patient name(s) ____

Signature (parent/guardian)________________________________ Date ______________________

Print Name (parent/guardian)_____________________________________

Relationship to Patient(s) ____