river city
pediatric dentistry

OFFICE AND FINANCIAL POLICIES

LAIS DALMAGRO PERUCHI, D.D.S.

At River City Pediatric Dentistry, we believe that your child deserves the absolute best care. We always present the best and most conservative dental treatments possible for your child. We are privileged to provide care for thousands of children in our area each year. Here are some important things you should know about our practice:

Please Initial After Each Applicable Section

Your family's dental benefits are based upon a contract made between you or your employer, and your insurance company. **If you have any questions regarding your dental benefits please contact your employer or your insurance company directly. Dental benefits are meant to assist you with the financial obligations of dental care and in most situations do not cover the entire cost of treatment.** □ _____

The doctors in our practice are in-network providers with several insurance plans. Whether we are in-network or out of network with your insurance company we will file your insurance claim on your behalf. Although we keep computerized histories of payment by a given company, they do change frequently and it is impossible to give you an exact quote at the time of service. We estimate your portion based on the most up-to-date information we have but it is **ONLY AN ESTIMATE.** If you would like to know a more accurate estimate of your insurance benefits, we will be happy to file a "pre-treatment estimate" with your insurance company prior to treatment. Please be aware that even the pre-treatment estimate from your insurance company is **still only an estimate.** □ _____

We will bill your insurance company as a courtesy. If your insurance does not pay within 60 days of the service, you will be required to pay the balance in full within 30 days from that date. **It is important that you recognize the insurance you have is a legal contract between you and your insurance company and so ultimately you are responsible for all charges incurred in our offices.** □ _____

After we receive a payment, (or notice otherwise), from your insurance company, we will send you a statement if there is a balance due. You will then have 30 days in which to make your payment in full. This may be paid by cash, check, credit card, or hold check. If the balance is not paid within 30 days, a $10 re-billing fee will be assessed to your account. This $10 re-billing fee applies to accounts even with very small balances. □ _____

We require payment in full for your estimated portion at the time of service if we are filing your insurance for you. We accept Cash, Check, Visa, MasterCard, AMEX, Discover, and Care Credit. □ _____

If you do not have dental insurance, you will be responsible for paying the balance of your account (not including Orthodontic payment plans) at the completion of each visit. We accept Cash, Check, Visa, MasterCard, AMEX, Discover, and Care Credit. □ _____

A specific amount of time is reserved especially for your child and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $50 broken appointment fee. □ _____

Once your child is established in our practice our doctors will always be available to your family in case of a dental emergency. In the event of an emergency after regular business hours a $55 emergency fee may be charged in addition to the necessary treatment fees. □ _____

Do we have permission to leave a voicemail concerning your account on the phone numbers you have provided to us? □ _____

I agree with the above conditions.

_____ Date: _____

Signature: Father, Mother, Guardian

Print Name_____ SSN_____ / _____ / _____

More On Back →

INFORMED CONSENT

Because_____ is a minor, it becomes necessary that signed permission is obtained from a
(Name of Patient)
parent or guardian before any and all necessary dental services can be rendered. I, being the (Father, Mother, Guardian) of the above named child, give my consent to River City Pediatric Dentistry to provide my child's dental treatment as deemed necessary, including digital radiographs (x-rays), diagnostic, preventive, restorative, oral surgery, and patient management techniques that are reasonable, necessary, and advisable to treat any dental/ oral deficiency, abnormality and/or infection. I authorize the dentist to release any information including the diagnosis and the record of treatment rendered to my child to third party payers and/or other health care practitioners. This authorization is valid until revoked by me in writing.

_____ Date: _____
Signature: Father, Mother, Guardian

Print Name_____ SSN_____ / _____ / _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have read a copy of the office's Notice of Privacy Practices.
(Parent or Guardian Name, Please Print)

Signature_____ Date_____

If you are the legal representative of the patient, describe your authority.

_____

Signature of Privacy Officer_____ Date _____