Pediatric Office Policies

1. We require at least 24 hours advance notice for appointment cancellations. Effective as of January 1, 2014, there will be a $75.00 charge for cancellations made within 24 hours of your scheduled appointment. If there are 2 broken appointments we reserve the right to charge a missed appointment fee of $75.00. More than 3 broken appointments may result in patient termination.

2. We reserve the right to reschedule an appointment for patients arriving more than (15) fifteen minutes late.

3. In the event that the patient's insurance coverage changes, please have the courtesy to call us ahead of time so we can provide adequate information and not delay treatment for your child or other patients.

4. **If nitrous oxide (laughing gas) is not covered by insurance and is used during the procedure there will an $100.00 fee, which must be paid at the scheduled appointment**.

5. **If oral sedation medication has been recommended, and is not covered by insurance, there will be a $225.00 fee, which must be paid at the scheduled appointment**.

6. ALL Coinsurance for any general anesthesia case MUST be paid 7 days in advance of the scheduled appointment.

7. All dental procedures that are not covered by your insurance (Private insurance or all state Medicaid plans) will have to be paid by the responsible party. Please review your dental benefits booklet carefully as each insurance company may have different coverage schedules.

8. In the case of divorce, custody, adoption, and/or guardianship issues, whichever parent/guardian brings the child to his/her dental appointment, that parent or guardian will be financially responsible for payment of co payments and deductibles regardless of who holds the insurance.

9. **There will be a $70.00 fee for all returned checks**.

10. If the parent/guardian is not the one bringing the child to the dental appointment, a handwritten note consenting to treatment MUST BE SENT OR WE CANNOT SEE THE CHILD.

11. Please be aware that a number of insurance providers are now bundling routine procedures such as x-rays into the patient's deductible. This means that even though it may be a covered service, the responsible party will have to pay for that procedure if the deductible has not been met.

My signature below acknowledges that I understand the office policies of this dental office. I further understand that my child's dental treatment is conditioned on the above policies. It is further understood that "we" refers to the dental offices of Dr. James L. Goldsmith.

_____
Date

_____
Patient's Parent or Legal Guardian's Signature

_____
Patient's Parent or Legal Guardian's Name (Print)