SAFARI SMILES DENTAL – OFFICE POLICIES

Our mission is to ensure that every patient has an experience that exceeds expectations. If a patient leaves our office saying, "Everything was OK", we have not accomplished our goal. We want to do better than "OK" – we want their experience to be exceptional. We want to deliver high quality dentistry in an environment that is extraordinarily fun, friendly, and comfortable.

Please initial each paragraph:

_____ **Financial Policy** – It is our policy to receive the patient's portion of payment in full at the time of service. Our office works with most insurance companies, and we will bill them as a courtesy to you. For your convenience we accept payment in cash, personal checks, and credit cards at the time of service. The office also has arrangement with Care Credit that may fit your financial needs.

_____ **Insurance** – We would be happy to file a dental claim with your insurance on your behalf, but YOU are ultimately responsible for all charges. We are happy to submit the claims necessary to see that you receive the full benefits provided and the limitations imposed. You should be aware that different insurance companies vary greatly in the types of coverage available and that some companies take care of claims promptly and other delay payments for many months. Please know that we will do everything possible to see that you receive the full benefits of your policy. Since Safari Smiles Dental is not a party to the agreement you have with your insurance company, you are ultimately responsible for all charges. If for some reason your insurance company has not paid their portion within a reasonable amount of time, generally 90 days, you will be asked to take care of the outstanding balance.

_____ **Estimates** – We will give you an ESTIMATE for your portion based on the information given to us by your insurance carrier. Please remember that this is ONLY an estimate. We will provide you with a written treatment plan at your new patient exam and all recall (six month checkup) exam. A treatment plan estimates include our fee, the estimated amount that your insurance will cover and what your out-of-pocket expense will be. If you have insurance, you must remember that these are ONLY estimates based on the information provided. Treatment plans may change depending on the needs of your child. We will always do our best to keep you informed of any changes.

_____ **Broken Appointments** – There is absolutely no charge for a broken appointment with more than 48 hours notice. There is however a $25 charge if 48 hour notice is not given. Most dental treatment requires a series of appointments with specific amount of time dedicated to complete the required treatment. This valuable time with our doctor and staff is reserved specifically for your child and their dental needs. Should you need to change a scheduled appointment, we would appreciate the courtesy of being informed a minimum of 48 hours in advance. No charge will be made for rescheduling an appointment with the required 48 hour notice.

I have reviewed the office policies and have been given the opportunity to ask questions to clarify any policy I did not understand. I have also read the Notice of Privacy Practices available at the office.

_____ _____

Parent/Guardian Signature Date

SAFARI SMILES DENTAL

Request and Consent for Pediatric Dental Treatment

I request and authorize the treatment and procedures outlined on the treatment plan for:

Patient Name: _____

Date of Treatment Plan: _____

Please initial each paragraph:

_____ I request and authorize the taking of dental x-rays.

_____ I give my consent to the use of local anesthetics and/or nitrous oxide as deemed appropriate to perform dental treatment as indicated on the patient's treatment plan. I have been informed that nitrous oxide (laughing gas, sleepy juice, happy air, etc.) may make my childe feel "tingly" or "floaty" and that the nitrous oxide will be completely dissipated from the patient's system after 2 to 3 minutes of breathing normal room air.
I also understand that while it rarely occurs, nausea is a possible adverse complication associated with nitrous oxide.

_____ It has been explained to me, and I have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment all together. I have also had the usual and most common risks or complications occurring from the planned treatment and procedures explained to me.

_____ I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I will be consulted prior to initiation of treatment procedures not listed.

_____ I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures that have already been performed.

_____ All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures prescribed for the patient on the treatment plan. Furthermore, I confirm that I have read and I understand this form and that all the blanks were filled in before I signed below.

_____ _____

Signature of Person Consenting to Treatment Date

_____

Printed Name of Consenting Parent/Guardian