Pediatric Dentistry & Orthodontics

Verification and General Informed Consent

Our philosophy is based on our commitment to nurturing well-being and creating a supportive environment for infants, children, and teenagers. We aim to deliver the highest quality pediatric and orthodontic dental care to each child in a safe and comfortable manner.

Our team will be working collaboratively to guide your child through their visit with warmth, friendliness, gentleness, humor, kindness, and understanding. Pediatric dentists use many behavior guiding techniques to gain the trust of child patients. The behavior management techniques used in our office are supported by the American Academy of Pediatric Dentistry. Several are summarized on this form.

It is our intent to provide our families with information regarding any treatment that we are recommending. Informed consent indicates your awareness of, and agreement with sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits, and alternatives, including the advantages and disadvantages of each treatment option.

Please read our forms carefully and ask about anything you do not understand or have further questions about. We are always happy to answer any questions that you may have.

Here are some behavioral management techniques that can be utilized in pediatric dentistry:

TELL-SHOW-DO: The dentist or assistant explains to the child what is to be done using simple, age-appropriate terminology and repetition. The procedure is then demonstrated to the child on a model (or the child's finger). Next, the procedure is performed gently as described. Praise is used to reinforce cooperative behavior. The method is meant to familiarize your child with new experiences, gain their trust and ensure their comfort.

POSITIVE REINFORCEMENT: Co behavior and genuine collaboration is acknowledged, appreciated and rewarded with compliments, praise, prizes, or stickers.

ONE-ON-ONE COMMUNICATION: Our team gives each child undivided attention. This allows the team to build a bond of trust with every child and gain his/her full attention and trust in a safe and open environment.

By signing this form, parent/caregiver agrees to the following:

I understand the listed methods of communication that can be used in a pediatric dental environment. I also understand that further specific dental/surgical procedures will be explained, if or when, I am presented with any additional dental restorative or sedation procedures that my child may need. Alternative methods, if any, will also be explained to me, as will the advantages and disadvantages of each. I understand that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and, therefore, no guarantee, is expressed or implied, as to the result of the treatment.

- I certify that the family, dental and health information I provided to Smiles Pediatric Dentistry & Orthodontics is complete and accurate to the best of my knowledge.
- I understand that it is my responsibility to notify the office of any changes in my child's health.
- I hereby authorize Smiles Pediatric Dentistry & Orthodontics to proceed with the necessary dental services that my child requires.
- I assume financial responsibility for the above-named child. I understand that payment is required in full at the time that services are rendered.

Acknowledgement of Receipt of Dental Materials Fact Sheet

I have received a copy of the dental materials fact sheet from Smiles Pediatric Dentistry & Orthodontics. Additional copies are available at www.smilesla.com

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the notice of privacy practices of Smiles Pediatric Dentistry & Orthodontics. Additional copies are available at www.smilesla.com

Consent for Use & Disclosure of Health Information

I have read the notice of privacy practices at Smiles Pediatric Dentistry & Orthodontics. I consent to the use and disclosure of health information for the process stated in this notice.

TREATMENT CONSENT AND FINANCIAL POLICY

Every child at Smiles Pediatric Dentistry & Orthodontics is unique. A tailored plan that best serves your child and is most comfortable for you is our goal.

1. Our administrative team will be explaining what fees to expect prior to your visit. Payments are due when treatment is rendered. We accept cash, ACH transfers, major credit cards, and debit cards.
2. **An active Credit Card will be kept on file for all open balances.**
3. For dental insurance benefits, we require the insurance information at least 72 hours in advance of the visit. This allows our office to file the insurance claim on your behalf. Please be familiar with your benefits to better understand the process. We file electronic claims that are paid within 30 days.
4. Please keep in mind that your insurance contract is between your insurance company and you or your employer. We are considered a third party. If you have questions about your specific plan, we encourage you to personally contact your carrier.
5. Our clinical team bases our individualized care and sound recommendations on what is in the highest good of your child rather than the limitations of insurance policies. As an example, many children benefit from more than two dental cleanings in one year or may need to return to see us at an earlier date than six months. Another example is the use of dental materials. Our office utilizes state-of-the-art materials.
6. For out of network PPO dental plans, our office collects payment at the time of treatment. Our team will assist you in processing the insurancer claim and will assign the insurance payment directly to you. You will receive a personal reimbursement check from your carrier based on your individual coverage.
7. For Delta Dental Premier plans, the portions of dental services that are not covered by the insurance company are estimated and are due at the time of service, along with any deductibles that apply.
8. Estimates of what your insurance plan will cover are based on your policy. There are times when insurance companies downgrade certain services. Outstanding balances for Delta Dental Premier plans are your responsibility and will automatically be charged to the credit card on file.
9. We strive to provide excellent pediatric dental care. Once your child's individualized treatment plan has been agreed upon, we make every attempt to complete it. Sometimes during the course of treatment, the initial treatment plan needs to be adjusted. This can occur if new dental findings were noted or if the carious lesion was more extensive than previously noted on the diagnostic image. Another circumstance is children undergoing deep sedation due to behavioral challenges. Often, diagnostic images are taken after the child is

sedated and therefore, the initial treatment plan might need to be changed. These changes will be clearly explained to you during the course of treating your child. Please note that these changes will affect the initial estimate and that you will be responsible for covering the difference in the amount.

10. If a treatment session is needed for your child, an exclusive time slot will be reserved with the doctor to complete the necessary care. Our office takes pride in the individualized care we provide for children. We do not overlap treatment appointments so that your child can have the doctor's undivided attention. Therefore, we kindly ask parents to inform us of any changes in their schedule 48 hours in advance.
    - *For routine visits, we reserve the right to charge a $150 fee per patient for families who do not honor our 48-hr notice policy.*
    - *For treatment visits, we reserve the right to charge 25% of the deposit for families who do not honor our 48-hr notice policy.*
11. Deposits are required when reserving a treatment slot with the doctors as follows:
    - **50% of the estimated fee for all treatment cases.**
    - Deposits are applied towards the estimated fee of the dental treatment. If a family has dental insurance, the deposit will be applied towards the portion of payment that is not covered by the family's insurance company.
12. **By signing this form, you give us permission to debit your account for any outstanding balances.**

My child's individual treatment plan has been discussed with me. All options of the proposed plan have been explained, and all my questions have been answered. I understand that changes may be made to the original treatment plan and that I will be informed of these changes. I have read and fully understand the financial policies of this office. I agree to be financially responsible for my child's dental care at Smiles Pediatric Dentistry & Orthodontics. I understand that this consent shall remain in full force and effect until cancelled by either myself or Smiles Pediatric Dentistry & Orthodontics. My signature, as a parent/guardian, on this form authorizes the completion of all agreed upon dental treatment and the use of the appropriate methods to do so.