CORONADO PEDIATRIC DENTISTRY

FINANCIAL ARRANGEMENTS:

Dental treatments are an estimate based on the recommendations of the doctor. You will be notified if any changes occur during treatment; **payment/copay is due in full at the time services are rendered.**

Authorization for direct insurance payment: I authorize payment directly to Howard R. Dixon, DBA: Coronado Pediatric Dentistry of insurance benefits for services rendered to my child(ren). I understand that I am responsible for all costs of the dental services rendered. Should the insurance benefits be insufficient (or disallowed) to cover the cost of the dental treatment, I will be responsible for the payment of all fees due. Any over payment on my part will be reimbursed to me.

I understand that the parent/legal guardian or authorized agent accompanying the child(ren) is responsible for estimated patient portion, in full, when services are rendered.

CANCELLATION/ MISSED APPPOINTMENT NOTICE:

We ask for 2 business days' (Mon- Fri) notice of any cancellation or to reschedule of a scheduled appointment during the week. **If Notification is not given, there is a $50.00 fee per routine appt and $100.00 fee per treatment appt (per child)**. We do our best to schedule siblings on the same day as consideration for the parents, but after 3 reschedules, cancellations and / or no shows, siblings will have to be seen on different dates as we have set the allotted time with doctor. The scheduling policy for siblings will apply to any appointment Monday through Saturday. **ANY** patient late more than 10 minutes, their appointment will have to be rescheduled as courtesy for other patients that are here for their appointment on time.

SATURDAY POLICY

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. When scheduled on a Saturday and there is a need to reschedule or cancel your appointment, we ask that you please provide us with at least 3 business days' notice (Mon- Fri) or a **$100 fee will charged on each child's account**. This courtesy makes it possible to give your reserved time slot to another patient.

***Please note that 2 or more rescheduled, cancelled or missed appointments will result in loss of future Saturday appointment privileges.**

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for the occasional interruption in our schedule for an emergency patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of an agreement with the above policies. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

Patient(s) Name:_____

Parent Signature: _____ Date: _____