## Vital information about your Dental Insurance

Insurance companies set their own schedules, and each company uses a different set of fees they consider allowable. When estimating dental benefits, deductibles and percentages must be considered. If we have received all of your insurance information and you have kept us current on any insurance changes, we will be happy to file the claim for you. Please be familiar with your insurance benefits, as this is a contract between you and the insurance company. At the time of service, we will collect from you the estimated portion that insurance is not expected to pay. By law your insurance is required to pay each claim within 30 days of receipt. We file insurance claims electronically, so your insurance company will receive each claim within days.

## Cancellation policy

Cancellations require a 24 hour notice. We reserve the right to charge $25.00 per child for not giving such notice. While we understand that circumstances happen that can cause you to cancel, please understand that we cannot fill a cancelled spot last minute.

## Consents for treatment and release of information

I give the doctor permission to use such measures as deemed necessary in his/her professional judgment to render a diagnosis for my child and to perform treatment. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I understand that dental treatments are meant to help save my child's teeth, but it is not guaranteed. When a treatment plan is put together, I understand that treatment may not go in order of the written plan. I understand treatment is done in the order that is best for the patient and that treatment may change if necessary once a procedure has started.

I have given an accurate report of my child's physical and mental health history. I have also reported any proper allergic or unusual reactions to drugs, food, skin or any other physical conditions that my child's medical doctor has advised me should be reported to the dentist.

I understand and consent to x-rays and other protected health information being sent via email for the purpose of referrals, treatment and collection from insurance.

Responsible party signature: _____ Date: _____

## Acknowledgement of receipt of Notice of Privacy Practices

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to the U.S. Department of Health and Human Services.

I, _____ (check one of the following)

□ I have read and I have received a copy of this office's Notice of Privacy Practices

□ I have printed and signed a copy of this office's Notice of Privacy Practices from the Littleton Kids Dental and Orthodontics website.

□ I have read this office's Notice of Privacy Practices and do not wish to have a copy.

Signature: _____ Date: _____

**-Below is for office use only-**

□ Individual refused to sign □ Communication barriers prohibited obtaining acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement □ Other (specify)