



Understanding Your Dental Insurance

Dental insurance is designed to help pay part of the cost of dental treatment. Dental insurance is not designed to pay all of the cost of treatment; it is more like a benefit towards the total costs.

We do our best to retrieve your child's dental benefits prior to their scheduled appointments. The information that we receive is not a guarantee of payment from your insurance company. They will only consider payment when a claim is received. The benefit information that we receive from them is very basic, meaning that the information that we provide to you is only an estimate based on the information provided to us. Since there is no guarantee that we will receive full payment from your insurance company, it is important to understand that ultimately you are responsible for your child's bill.

Initial _____

Financial Consent

I acknowledge that I have read and agree with the office financial policy. I understand that any estimate of my insurance benefits is solely an estimate and not a guarantee of payment. I understand that this office bills my insurance as a courtesy and is not required to file my claims either legally or contractually. I am ultimately responsible for knowing the benefits and limitations of my plan. I understand that this office may place composite (tooth-colored) fillings and I may have a higher copay if my insurance only covers amalgam (silver) fillings for back teeth. I also understand other charges such as (but not limited to) nitrous oxide (laughing gas) and fluoride may not be covered by insurance and will be my financial responsibility.

Initial _____

I certify that I have given the correct insurance information to the office and will notify the office of any changes in insurance company coverage. I also understand that fees and treatment needs are subject to change and previous estimates are not to be considered a guarantee.

Initial _____

I acknowledge that payment in full is expected in cases of no insurance unless extended financing has been obtained.

Name of Parent/Guardian _____

Signature _____ Date _____





General Consent

I request and authorize Harmony Pediatric Dentistry to perform examinations, cleanings, radiographs (x-rays), photographs, and fluoride for my child as necessary. I understand that any treatment needs will be explained to me prior to treatment and I give consent for Dr. Tee to do recommended treatment as needed.

I state that I am the child's legal guardian and that I have read and agree to follow all office policies stated on the website and available within the office. This consent will remain in effect unless cancelled in writing.

I agree to notify this office of any change in my child's health, including any allergies or current medications/supplements. As well as any changes in contact and insurance information.

I authorize Harmony Pediatric Dentistry to release any information necessary to any providers pertaining to my child's dental care and for processing of dental insurance claims and authorize direct payment from the insurance company to Harmony Pediatric Dentistry.

Name of Parent/Guardian _____

Signature _____ Date _____

Acknowledgment of Receipt of Notice of Privacy Practices. You may refuse to sign this acknowledgment.

I have reviewed a copy of Harmony Pediatric Dentistry notice of privacy practices.

Name of Parent/Guardian _____

Signature _____ Date _____

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We attempted to obtain Acknowledgment of Receipt of our notice of privacy practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign ☐ Communication barriers prohibited obtaining acknowledgment
☐ Other _____





To make sure that every patient gets individual attention, we set aside dedicated time for each appointment. Our staff takes the time to prepare for each appointment by sterilizing, organizing, and setting up the room specifically to meet your child's needs prior to your arrival. This ensures that your child receives the highest quality of care that we pride ourselves in.

Running Late

Arriving more than 10 minutes late for an appointment will require rescheduling. We will do everything we can to accommodate you; however we schedule each appointment according to the time needed to provide quality care for your child. If you are late to your appointment it doesn't allow us to provide the quality of service that we strive for. Please call if you are going to be late. Our office makes every attempt to be on time, but we do run on "kid time". Some children require additional time, and understand that we will do the same for your child as needed.

Cancellations

Because appointed times are reserved exclusively for each patient we ask that you please notify our office 48 hours in advance if you are unable to keep your appointment. Another patient who needs our care can be scheduled if we have sufficient time to notify them. We realize that unexpected things can happen, but we ask for your cooperation.

No Shows

If no notice is given and your child no shows to a scheduled appointment, we may ask that your child be seen by another dental office for future appointments.

By signing this policy, I have read and understand the cancellation policy.

Name of Parent/Guardian _____

Signature _____ Date _____

