FINANCIAL POLICY

Thank you for choosing our office for your child's dental healthcare. We are committed to their successful treatment! Please understand that *payment of your bill is considered a part of your child's treatment.* The following is a supplement to our **Payment Policy** which you received in the New Patient Information Folder.

Please be aware that the parent bringing the child to The Kids Spot Dentistry *is legally responsible for payment of all charges.* We cannot send statements to other persons.

- **Co-Payment is expected in full for each appointment as services are rendered.** For the convenience of our patients, we accept cash, MasterCard, Discover or VISA.

- **Dental Insurance** – There is no direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. *We will accept assignment of benefits from your insurance company; however you are responsible for the full balance including any amount that is not paid by your insurance company.*

- **Emergency Treatment** – all emergency treatment must be paid in full at the time the service is rendered.

We recognize that under unusual circumstances an account balance may be incurred. The Kids Spot Dentistry requires that all outstanding balances *be paid in full within thirty (30) days unless other arrangements have been made.* Thank you in advance for your understanding of our financial policy!

_____ _____

Parent/Legal Guardian Date

_____ _____

Witness Date

Consent for Dental Treatment

I request and authorize Dr. Potts and associates to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Potts and associates to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Potts and associates will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstrating of procedures and instruments, and using variable voice tone. I will be responsible for any changes incurred on this child for dental treatment.

Signature_____ Date_____