OFFICE POLICIES FORM FOR KATAHDIN PEDIATRIC DENTISTRY

Date: _____

Patient Name: _____

APPOINTMENTS:

Confirmation: Due to the high demand for our dental services, it is necessary to minimize time lost due to failed appointments. Therefore, we have the following **appointment confirmation policy**: **Appointments are to be confirmed by telephone or text at least 48 hours in advance of the scheduled appointment.** If you must change an appointment, please call us **at least 48 hours** in advance for any **office visit**, and **at least 72 hours, or three days,** in advance for **oral sedation. Failure to call in advance is considered a failed appointment. If you fail more than two appointments within a one year period, your child will not be scheduled for future appointments, unless it is an emergency.** If the appointment is not confirmed and we are unable to reach you at the number you provided, it will be considered a failed appointment.

Tardiness: We understand that incidents may occur (traffic, weather, accidents etc.) that are beyond your control. If you call us with an estimated time of arrival, we will be able to assess whether your child can still be seen, or if you must be rescheduled. If your child is late, the appointment may have to be modified (fewer services performed.) If your child is more than 10 minutes late, we will work with you to reschedule the appointment for another time. **It is your responsibility to provide us with updated phone numbers and addresses in the event that either of these changes**.

PAYMENT: Payment for services is due at time of visit. If you have insurance, the patient's estimated portion will be due. For those who qualify, payment arrangements may be made. For questions regarding payment of treatment plan options, please ask to speak to our financial administrator or a manager. **There is a $ 50.00 charge for all returned checks**.

DENTAL INSURANCE: We accept all insurances in our office with one exception* We are a participating provider only for Northeast Delta Dental *PPO*, Northeast Delta Dental *Premier*, Cigna, and Maine Care. We will gladly process your insurance claims for you; however, you are responsible for anything that insurance does not cover. It is your responsibility to provide proof of insurance, understand your insurance policy, and contact your insurance carrier to obtain a summary of benefits.

** We do not accept Federal BCBS insurance but can work with you to help you receive benefits from this insurance company.*

***MAINECARE BENEFITS:** All MaineCare recipients are responsible for any services **NOT** covered by MaineCare. Payment is due at the time of service. Our insurance administrator is able to explain which procedure(s) MaineCare does not cover. If your child does not have active MaineCare on the day of service, we will be glad to reschedule, unless there is an emergency.

EMERGENCY TREATMENT: Our office is open Monday through Friday however will be closed certain days of the month. If your child is having a dental emergency that involves pain and/or swelling, please call us as soon as possible. If the dentist is not available the day you call; or if you are having a dental emergency after hours please call or seek treatment at your local emergency room. For scheduled emergency appointments; treatment is NOT guaranteed the day of the exam with the dentist.

REFERRALS FOR SECOND OPINIONS: There are times when it is appropriate for us to refer you to another office for additional evaluation, second opinion or treatment.

PARENT IN THE ROOM: We welcome and encourage you to be with your child for their appointments, regardless of age. We ask this be limited to one adult. We limit this privilege for some treatments, when necessary. Additional exceptions are made based on the doctor's assessment to benefit the care of your child. There are guidelines you are expected to follow. We ask our families to adhere to a dress code similar to most school systems; please see team members should you require the dress code policy handout.

OTHER REQUIREMENTS: Under no circumstances is it acceptable to verbally assault any member of our staff. Profanity and name calling are strictly prohibited. **Under NO circumstances may the appointed adult leave the minor at our practice for any reason.** Such persons to abuse either requirement will result in immediate dismissal of the entire account from the practice.

LEGAL GUARDIANSHIP: I understand that I must be present in the office during treatment of my child. In case I am unable to present to the dental office, the following person can consent for treatment (Name): _____. Their relationship to my child is that of: _____. *This does NOT apply to oral sedation, hospital, or other advanced behavioral techniques; *i.e. a parent or legal guardian **MUST** be present for those forms and treatment.*

I have read and received a copy of these policies. All my questions have been answered regarding these policies.

Signature: _____ Date: _____

Date last modified: 6/5/2023

I ACKNOWLEGE THAT I HAVE RECEIVED A COPY OF THIS Dental Practice's **HIPAA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

Who may we release information to regarding the above patient:

_____	_____
_____	_____
_____	_____
Name	Relationship

_____ _____
Signature of Parent/Guardian Date

Authority of Personal Representative to Sign for Patient (check one)
☐ Parent ☐ Guardian

OR

_____
Patient Signature (If over 18 years old) Date

Please note: It is your right to refuse to sign this Acknowledgement.

_____
Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices,** but it could now be obtained because:

_____ An emergency prevented us from obtaining acknowledgement.

_____ A communication barrier prevented us from obtaining acknowledgement

_____ The individual was unwilling to sign

_____ Other:_____

_____ _____
Staff Member Signature Date