Financial Policy

We are committed to providing your family the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions regarding our Financial Policy.

Please note the following:

- We must have a completed Patient Information Form before we can see your child in our office, signed by a Parent or Legal Guardian.
- Full payment is due at the time treatment is rendered, including deductible and estimated family portion/co-payments.
- A fee will be assessed for any returned check. After two returned checks we will no longer accept checks as payment on account.
- A $25 fee will be assessed for all broken appointments. This is a **"no show"** appointment without 24 hours notice.
- We gladly schedule siblings on the same day for your convenience; however, this does require dedicating more time to one family. In the event of a broken appointment the $25 broken appointment fee will be assessed and we will be unable to schedule the siblings together in the future.
- A $250 fee will be assessed for all broken **sedation appointments** without a 24 hour notice.
- A $220 fee will be assessed for all broken **outpatient surgery appointments** without a 24 hour notice. This will be waived only if the child's physician has cancelled the appointment due to illness, and documentation from the physician must be provided.

INSURANCE:
We are happy to file insurance claims for those patients with dental insurance. We do not charge for this service; it is a courtesy to our patient families. It is the responsibility of the family to provide our office with correct dental insurance information for submitting the claim as well as knowledge of the plan limitations, benefits and yearly maximums. Please be advised that we are not Preferred Providers for all dental plans.

I have read and acknowledge the above policies

Parent/Guardian Signature Date

Jade Miller, DDS **Pediatric Dentristy** **Gilbert A Trujillo, DDS**

Consent for Treatment and Release of Information

Patient Name:_____

Date of Birth:_____

1. I, the parent or legal guardian of the above minor patient, hereby authorize and request the performance of dental services for this patient by Jade Miller, DDS and/or Gilbert A. Trujillo, DDS and staff. I have authority to authorize these services.

2. I authorize Jade Miller, DDS and/or Gilbert A. Trujillo, DDS and staff to perform diagnostic procedures and dental treatment determined by the Dentist to be reasonable, necessary and advisable.

3. I authorize the administration of local anesthetics (numbing medications) or analgesics that may be deemed necessary and advisable by Jade Miller, DDS and/or Gilbert A. Trujillo, DDS in order to complete dental treatment safely and comfortably.

4. I understand that behavior management techniques (such as arm/leg control) may be necessary when working on some children in order to prevent injury to that child this includes voice control and tell, show and do. If these techniques become necessary for my child, I give authorization. This **does not** include restraining devices, such as a papoose.

5. I authorize release of any information concerning my child's treatment to another dentist or physician for reasons including referrals, consults or record transfer.

6. I authorize release of any information concerning my child's treatment for the purpose of obtaining preauthorization or payment of insurance benefits.

7. I authorize release of any information concerning my child's treatment or account to the other parent or other legal guardian of my child, if any.

8. I authorize payment of insurance benefits to Jade Miller, DDS and/or Gilbert A. Trujillo, DDS otherwise payable to the insured.

9. I understand that the treatment plan presented, along with the fees outlined, could change depending upon the time elapsed since the examination, the extent of dental pathology, the ability to complete the initial examination, the ability to obtain x-rays due to my child's age, special needs or behavior.

I understand that payment is expected when services are rendered either by cash, check or credit card. I understand that insurance will be filed as a courtesy to me. I understand that Drs. Miller and Trujillo are not preferred providers for all insurance companies. I understand it is my responsibility to provide the business staff with the correct information for submitting insurance claims. It is my responsibility to know the benefits, maximums, frequency, limitations and deductibles of my insurance plan. I agree to pay the estimated family portion determined at the time services are provided for my child and any remaining balance. I understand that a fee will be assessed for any returned check. After two returned checks we will no longer accept checks as payment on account.

10. I understand that my dental insurance carrier/administrator may pay less than the actual bill for services provided to my child. I understand that I am responsible for payment in full of all account balances. I understand that a finance charge will accrue on accounts over 30 days past due, at annual percentage rate of 18%.

11. My child has Medicaid or Nevada Check Up? _____Yes _____No

12. I understand that in the event that my child is eligible under the Medicaid /Nevada Check Up program as a secondary insurance coverage and this practice is not a preferred provider for my primary insurance that the Medicaid/Nevada Check Up will not cover any procedures and I will be responsible in full for what my primary insurance does not cover.

Statement/Billing Address:_____

_____

Date: _____

Signature of Parent or Legal Guardian:_____

Date:_____

Signature of Parent or Legal Guardian:_____