GROWING Smiles Pediatric Dentistry

Kellie McGinley, DDS
Board Certified, Diplomate
Licensed Pediatric Specialist

Gilbert A. Trujillo, DDS
Licensed Pediatric Specialist

Emily Whipple, DMD
Board Certified, Diplomate
Licensed Pediatric Specialist

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.

Patient Name: _____Date of Birth: _____

Please note the following:

- We must have a completed Patient Information Form signed by a Parent or Legal Guardian before we can see your child in our office. We are required to obtain an annual update, as well. _____ **Initial**
- **Payment in full is expected when services are rendered** either by cash, check or credit card. If your child has dental insurance, payment is expected for the estimated family portion determined at the time services are provided and any remaining balance. Insurance will be filed as a courtesy. It is your responsibility to provide the business staff with the correct information for submitting insurance claims. It is your responsibility to know the benefits, maximums, frequency, limitations and deductibles of the insurance plan. _____ **Initial**
- The dental insurance carrier/administrator may pay less than the actual bill for services provided to my child. You are responsible for payment in full of all account balances. A finance charge will accrue on accounts over 30 days past due, at the yearly percentage rate of 18%. _____ **Initial**
- A fee will be assessed for any returned checks. After two returned checks we will no longer accept checks as payment on the account. _____ **Initial**
- A $55.00 fee will be assessed for all broken appointments. This is a **"no show"** appointment without a 24-hour cancellation notice or a **"cancelled"** appointment without a 24-hour cancellation notice, made within business hours. _____ **Initial**
- 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 $55.00 broken fee appointment will be assessed and we will be unable to schedule the siblings together in the future. _____ **Initial**
- A $325.00 fee will be assessed for all broken or no show **Oral Conscious Moderate Sedation appointments** without a 24-hour notice made within regular business hours. _____ **Initial**
- A $500.00 fee will be assessed for all broken or no-show **Hospital/General Anesthesia appointments** without a one-week notice made within regular business hours. This will be waived only if the child's physician has cancelled the appointment due to illness and documentation must be provided. _____ **Initial**
- 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 the primary insurance, Medicaid/Nevada Check Up will not cover any procedures and I will be responsible in full for what my primary insurance does not cover. _____ **Initial**
  My child has Medicaid or Nevada Check Up? _____Yes _____ No

I have read and acknowledge the above policies

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print Name Parent/Guardian Relationship to Patient

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Consent for Treatment & 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 Kellie McGinley DDS, Gilbert A. Trujillo DDS and/or Emily Whipple DMD and staff. I have authority to authorize these services. _____ **Initial**

2. I authorize Kellie McGinley DDS, Gilbert A. Trujillo DDS and/or Emily Whipple DMD and staff to perform diagnostic procedures including radiographs and dental treatment determined by the dentist to be reasonable, necessary and advisable. _____ **Initial**

3. I authorize the administration of local anesthetics **(numbing medications)** or analgesics that may be deemed necessary and advisable by a dental provider of Growing Smiles Pediatric Dentistry in order to complete dental treatment safely and comfortably. _____ **Initial**

4. I understand that behavior management techniques (such as protective stabilization of the body/arm/legs) may be necessary when working on some children in order to prevent injury to that child or staff. This also includes voice control and tell-show-do. If these techniques become necessary for my child, I give authorization. _____ **Initial**

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. _____ **Initial**

6. I authorize release of any information concerning my child's treatment for the purpose of obtaining preauthorization or payment of insurance benefits, if applicable. _____ **Initial**

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

8. I authorize payment of insurance benefits to Kellie McGinley DDS, Gilbert A. Trujillo DDS and Emily Whipple DMD otherwise payable to the insured. _____ **Initial**

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. _____ **Initial**

Parent/Legal Guardian (Signature): _____ Date: _____

Parent/Legal Guardian (Print Name): _____ Date: _____

Parent/Legal Guardian (Signature): _____ Date: _____

Parent/Legal Guardian (Print Name): _____ Date: _____