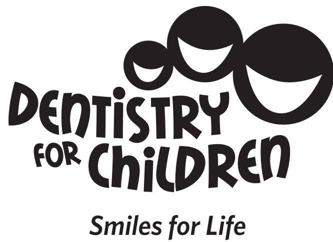

dentistry4children.com

PATIENT CONTRACT

We are happy to have the pleasure of meeting your child's dental needs at Dentistry for Children, PC. Please read carefully and sign the following agreement of terms in order to be accepted into our practice.

- I understand that I must have a current Medicaid/Peachcare form present each visit in order for my child to be seen.
- If I can not be reached to confirm my child's appointment; I am responsible for contacting Dentistry for Children within 36 hours to confirm my appointment, otherwise my appointment time may be given away.
- I understand that after repeat failed appointments, I may not be able to reschedule.
- I understand that I am responsible for notifying Dentistry for Children of any changes in my address or telephone number.
- I understand that a parent or guardian must accompany my child.
- I understand that my presence in the office is required while my child is being treated at Dentistry for Children, PC.
- I understand that I am responsible for notifying Dentistry for Children, PC of any other insurance coverage for my child.
- I understand that I am responsible for any charges not covered by Medicaid/Peachcare due to frequency, and non-approved procedures or lack of coverage.
- As a courtesy to you, Dentistry for Children will issue a placeholder for 6-month appointments on your child's recall program, awaiting your confirmation.

Examples:

a) A Panoramic (full-mouth) x-ray will not be covered if one was taken at another dental office in the previous three years.

b) Emergency exams during office hours are only covered twice per year. The parent or guardian will be responsible for payment of any other emergency exam for the remainder of the year.

Payment is expected in full at each visit for any procedure not covered by Medicaid or Peachcare. These items will be explained to you before they are done for your child.

By signing, I agree and fully understand the terms stated in this contract. If at any time I do not abide by these terms - my child will not be scheduled at Dentistry for Children, P.C.

Parent or Guardian: ______________________________ Date: ________________