RANDY SMITH PEDIATRIC DENTISTRY, PA
FINANCIAL POLICY

Thank you for choosing us for your Dental Care. We are fully committed to your needs, and want you to have a successful experience while in our office. Please understand that payment of your bill is considered part of your treatment, and that responsibility is ultimately yours as a parent/guardian.

We DO NOT carry account balances in our office, but we do have several options. The following is our Financial Policy which we require you to read and sign prior to treatment.

- **INSURANCE:** We will file your insurance as a service to you and will do our very best to maximize your benefits. All Co-pays, Deductibles and Portions are to be paid at the time of service. Your insurance policy is a contract between you and your insurance company, and we are in no way a party to that contract. Our fees generally, but not necessarily, fall within the usual and customary fee structure determined by your carrier. It is crucial you understand your policy, as some services we provide may not be covered. You are ultimately responsible for full payment regardless of any insurance company's determination of usual and customary rates. We reserve the right to collect full payment at the time of service even if you have insurance in force.

- **PAYMENT IN FULL:** We offer a discount to those who wish to pay in full on the date of service. If you DO have insurance, we can give you our discount, but you will be required to file your own insurance. A 5% discount can be given for services totaling $1000 or less, and a 10% discount for services totaling over $1000. We accept CASH, CHECKS, VISA, DISCOVER, MASTERCARD, and AMERICAN EXPRESS.

- **EXTENDED PAYMENT PLANS:** We do not offer credit terms directly, but we have entered into an agreement with *Dental Fee Plan™ by Capital One, and/or CareCredit™ by GE Money Bank*, to provide these kinds of services to our patients. Application is quick and easy and can be made by phone call, or if you prefer, can be applied for online. Approval is typically granted immediately. There are a variety of options with each plan, and we can provide you with the information necessary and specific to your needs. These plans can even offer up to **12 months interest and fee free!**

- **MISSED APPOINTMENTS:** Unless canceled 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00. If more than THREE appointments are missed, we reserve the right to dismiss you as a patient.

- **RETURNED CHECKS:** If your check is returned to us for NSF, a $20.00 service charge will be applied to your account.

- **MINOR PATIENTS:** The adult presenting a minor for treatment is responsible for FULL payment at the time of service, regardless of their relation to that patient. For unaccompanied minors, non-emergency treatment may be denied unless charges have been pre-authorized to an approved credit plan, credit card, or by cash.

These financial options should meet the needs of most families in our practice. We will do our very best to work with you to assist in the best financial solution to your particular situation. Please just ask us, we are here to help you. Thank you, and let us know if you have any questions or concerns.

I understand and agree to this Financial Policy.

X______________________________________ Date________________________

Signature of Patient or Responsible Party

Revised 4/08

Randy G. Smith, D.D.S.
Pediatric Dentistry

3365 S. Holmes Ave.
Idaho Falls, ID 83404
(208) 542-1333

CONSENT FOR DENTAL TREATMENT

Patient:______________________________ Date:_________________

I hereby authorize Dr. Smith and Dr. Marlowe and his staff at 3365 S. Holmes Ave Idaho Falls, ID 83404 to perform upon the named patient the following procedures: exams, cleanings, or treatment as needed.

I understand that during the course of the procedures, unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional procedures which Dr. Smith or Dr. Marlowe may consider necessary.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedures.

I confirm that I have read and fully understand the above. I hereby consent to the proposed dental treatment.

____ _____________________
signature of Patient or Guardian Date

____ _____________________
Interpreter (if used) Date