



Consent for Treatment Financial Agreement Photo Consent Assignment of Benefits Authorization

As responsible party for (patient name) _____, I hereby give consent for the following Dental Treatments and evaluations to be performed by the Dental Professionals of Child Style Dental LLC.

- Cleaning including Fluoride treatment
- X- Rays for diagnosis and evaluation
- Fillings
- Extractions
- Caps or Crowns
- Nitrous Oxide (used to keep the patient comfortable)
- Space maintainers
- Nerve treatments” pulpotomy”

All treatment plans and financial responsibilities will be discussed with the Responsible Party prior to beginning treatment. Parents are welcome and encouraged to share in the initial visit by joining the child for their cleaning and exam. Children are encouraged to come back for their restorative procedures on their own to facilitate the doctor patient relationship.

Cancellations or missed appointments: We understand that circumstances change and unexpected family commitments can alter every day plans. Please let us know as soon as possible so that we may offer your appointment time to another family that maybe waiting to be seen. If an appointment is missed, and we do not hear from the responsible party, the child’s appointment will be logged as a “failed appointment”. Two Failed appointments will be forgiven but three will result in being dismissed from the practice. Child Style Dental, LLC reserves the right to charge a \$25 fee for missed appointments.

- I understand that I am personally responsible for any and all charges incurred by the patient from services rendered by Child Style Dental LLC
- Unless other arrangements are made in advance with the financial department of Office Manager, the total charges are due and payable at the time of services.
- I understand that it is the Policy of Child Style Dental LLC to file my dental claims and have the insurance payer to mail reimbursement directly to the address provided.

I understand that my insurance company does not guarantee benefits over the phone. The portion of coverage by my insurance is an ESTIMATE. I understand that an insurance policy is as contract between me and an insurance carrier and that I am personally responsible for charges rendered by Child Style Dental LLC regardless of claim status. I acknowledge that payment is due at the time of treatment and I except fun financial responsibility for all charges not covered by insurances. If the account is referred to a collection agency I am responsible for the balance in addition to any collection agency fees and or attorney fees that are incurred.

I hereby agree to all terms set forth herein and authorize treatment, and release of any medical information necessary to process my insurance claims.

Signature of Responsible Party: _____ Date: _____

Address of Responsible Party: _____

City: _____ State: _____ Zip: _____

PHOTO CONSENT: As a pediatric specialty office, Child Style Dental, LLC frequently offers continuing education for parents, children and physicians that may have questions about oral healthcare. We would like permission to take photos of your child’s teeth. The photo would not include a name.

I hereby give consent for Child Style Dental, LLC to take photos of my child’s teeth for training and education purposes only. I understand that this will not be used for advertising and will not be used for any other purpose other than education.

Signature of Responsible Party: _____ Date: _____