Mountain Kids Pediatric Dentistry

Patient Information

Child's Name:____
Last *First* *Sex: M/F* *Date of Birth* *Age* *SSN/Medicaid #*

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Responsible Party Information

*The parent or guardian that **signs this paperwork** is the Responsible Party or Guarantor of financial account. This may be different than the provider of insurance.*

Name: ____
Last *First* *Date of Birth* *SSN* *Marital Status* *Relationship to patient*

____
Address (street, city, state, zip code) *email address*

______________________ ______________________ ______________________
Home phone *Cell phone* *Work phone*

____
Employer *Employer Address* *Years employed*

____
Guarantor Signature *Date*

Other persons authorized by guarantor to have access to HIPAA protected financial information regarding the account and/or seek treatment for your child(ren). All authorized persons must identify themselves to staff. Please check boxes (☐) for emergency contacts.

☐ **Other Parent Name:** ____
Last *First* *Date of Birth* *SSN* *Marital status* *Relationship to patient*

____
Address (street, city, state, zip code) *email address*

______________________ ______________________ ______________________
Home phone *Cell phone* *Work phone*

☐ **Other**: ____
Last *First* *Relationship to patient* *Phone*

☐ **Other**: ____
Last *First* *Relationship to patient* *Phone*

Insurance Information

If you expect insurance to pay for services, please make sure to present insurance card. You must inform us of any changes when calling to schedule appointments.

Subscriber Information: ____
Last *First* *Date of Birth* *SubscriberID/SSN* *Relationship to patient*

__________________ __________________ __________________ __________________
Employer Name *Insurance Company* *Insurance Phone Number* *Group Number*

Mountain Kids Pediatric Dentistry

CONSENTS

Welcome to Mountain Kids Pediatric Dentistry. Please take a few minutes to review the following financial agreement and Receipt of Notice of Privacy Practices. We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this office for our patients and the community. ***Please initial each paragraph***.

_____ Charges for dental services at our office are due and payable at the time the services are rendered. We accept cash, check, Visa, MasterCard, Discover and Care Credit. For in-hospital services provided by our doctors, copays and deductible estimates are due at the time of service and, as a courtesy, we will submit the covered charges to your insurance and allow 45 days for payment. At that time you will be required to pay the full charges and settle with your insurance company. Please understand that your insurance is an agreement between you and your insurance company to pay a certain amount for your care. Our bill for services is an agreement between you and our office. You are responsible for the payment of your bill regardless of the status of your insurance claim. If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our Financial Manager. This will avoid misunderstanding and enable you to keep your account in good standing. Mountain Kids Pediatric Dentistry reserves the right to assess finance charges of 18%APR on account balances on a monthly basis. Accounts 90 days past due are referred to a collection agency, unless prior arrangements have been made with our office. Also, we will no longer be able to provide for your (dependent) care.

_____ 'I request that payment of authorized dental or any other applicable health insurance benefits be made either to me or on my behalf to Mountain Kids Pediatric Dentistry for any services provided to my dependant(s). I authorize any holder of dental/medical information about my dependant(s) to release any information needed to determine benefits or benefits payable for related services to the applicable insurance agencies.'

_____ In order to be respectful of the doctors and all patients' time, kindly give sufficient notice if you are unable to keep your appointment. If appointments are rescheduled without 48 hours notice, you may be charged a fee. If you miss three appointments without prior timely notice, you may be discharged from the practice. If more than 10 minutes late, we may ask you to reschedule for another time.

If you should have any question regarding the above policies, please feel free to discuss it with our Practice Administrator.

Signature: _____ Date:_____

Before any dental treatment can be performed for a minor, we must obtain signed permission from a parent or legal guardian. Specific treatment needs and options will be discussed with parents prior to all dental procedures.
'As a parent or legal guardian of the above patient(s), I acknowledge that the above information is correct and grant Mountain Kids Pediatric Dentistry permission to provide my child's dental and related medical/surgical treatment as deemed necessary, including digital radiographs (x-rays), diagnostic, restorative, oral surgery, and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics or analgesics that are advisable by Dr. Guido or Dr. Rusnak, such as nitrous oxide (laughing gas).'

Signature: _____ Date: _____

I authorize Mountain Kids Pediatric Dentistry the right to take photographs of me and my family. I agree that Mountain Kids Pediatric Dentistry may use such photographs of me and my family with or without my name and for any lawful purpose, including and for example such purposes as publicity, illustration, advertising, and Web content.

Signature: _____ Date: _____

A copy of the **Notice of Privacy Practices** for Mountain Kids Pediatric Dentistry is available to you; please ask the Receptionist when you arrive if you would like a personal copy of them. This notice describes how Mountain Kids Pediatric Dentistry may use and disclose your child's protected health information, certain restrictions on the use and disclosure of their healthcare information; and rights you may have regarding your child's protected health information.

Signature: _____ Relationship to patient: _____

Name of Patient(s): _____ _____

_____ _____