Consent for Treatment and Billing

Patient name: Test Test **Date of Birth:** 07/05/1935

Thank you for choosing Smiles2Be Pediatric Dentistry as your child's dental health care provider. Our goal is to provide superior dental care for your child while communicating costs with complete transparency. Below is our Financial Policy, which we require you to read and sign before treatment.

I authorize Smiles2Be to provide health, medical, dental, counseling and educational services and any treatment related to these services to myself or the aforementioned minor.

Smiles2Be will decide, at its sole discretion, which person (employee or individual contractor) will perform such treatment. I understand that the services and treatment mentioned above do not involve an exact science and the results are not always known or are guaranteed. I understand that tests may be performed to detect blood borne diseases (including HIV/AIDS) to a patient without separate written consent in the event that a health care employee or professional of Smiles2Be has occupational exposure, percutaneous, through open wounds, mucous membranes to blood or blood fluids.

I hereby give permission to Smiles2Be to bill any insurance I have. For the present document, I authorize my insurance company to make direct payment to the dental office listed above for the dental benefits I receive. I understand that any insurance estimates provided are ESTIMATES only and not a guarantee of payment. Although we may provide you with a treatment estimate, it is ultimately your responsibility to know the benefits, limitations, exclusions, and stipulations of that contract. I understand that I am responsible against any amount that is not covered by my insurance and I agree to pay in a period of 30 days any outstanding balance for me, my dependents and of any other that is in my account.

Payment Policy: Payment is due at the time service is rendered. If we participate with your insurance plan, we will collect an estimated coinsurance amount at that time.
1. We accept cash, Visa, MasterCard, American Express, and Discover.
2. Third Party Financing may be available, subject to review and approval.
3. Depending on your child's needs, we may recommend treatment be performed in a surgical setting under the care of a licensed anesthesiologist. As a result, you may incur fees from the facility and its contractors. By signing below, you acknowledge these costs as separate from Smiles2Be Pediatric Dentistry and assume liability for uninsured amounts.
4. Balances not paid in full within 90 days are subject to a $25.00 late fee.

Minor Patients:
1. Payment for the treatment of minors is the responsibility of the adult accompanying the child at the time of service.
2. In the case of divorced or separated parents, it is your responsibility to make financial arrangements with the other party before your son or daughter arrives.
3. The parent or guardian signing this form accepts final responsibility for all costs associated with your child's care. This includes applicable service fees, collection fees, and/or court fees incurred on delinquent accounts.

For the present document, I authorize Smiles2Be and its staff to release information regarding my child's care, medical or dental, and treatment to my dental insurance carriers, claims administrators, and consulting health care professionals for the administration and payment of my claims and coordination of care. Until Smiles2Be is notified in writing, this consent will remain in effect. I have read and understood the consent form and I sign it freely and voluntarily. I understand that I have right to receive a copy of this authorization.

Parent/Guardian's Name: ______________________________

Relationship to Child: ____________________

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Date: Wednesday, September 18, 2024