WELCOME TO TOOTH TRANSITIONS PLLC

This form is designed to acquaint you with our Office Policies. You have the opportunity to question, at this time and prior to service, the Office Policies and Procedures in the following areas of concern. PLEASE INITIAL EACH ITEM.

___This office employs licensed, Pediatric Dentist(s) and Dental Hygienist(s) who will be involved in your patient care and providing your dental treatment.

___Please note, our relationship is with you and not your insurance company. (*As a courtesy we will verify and file your dental benefits, however any portion not covered by insurance is your responsibility.*)

___Policy on Cancellation & Rescheduling, 24hrs notice is required. *(You will receive a REMINDER call from our office 48hrs prior to your appointment.)*

___Failure to give us notice of cancellation 24 hrs prior to your appointment will result in restricted scheduling. If this offense occurs more than 2 times you will be dismissed from the office.

___Patients are responsible to know their insurance benefits prior to first visit.

___NSF Checks Recovery ($25.00) Recovery Fee (There after Cash or credit card only.)

___Statements are billed twice a month. Expectant payment within 10 days of statement date. Public Aid Insurance claims are sent out daily.

___Insurance Billing –Insurance claims are sent out on the same day of service.

___Notification of change of insurance; job; name, phone and address is the parent/guardian's responsibility.

___Phone calls are triaged by my Dental Assisting Staff. Please know that my staff is an extension of me and all patient matters have been discussed with me. However, when it is necessary to call you myself, please understand that all calls are returned at the end of the working day.

___Diagnostic and Treatment Codes for billing will not be altered for insurance purposes.

___Pharmacies: patients must supply the office with their pharmacy phone number.

___Co-pay and Service Fees are due at the time services are rendered.

___All patients' initial visit must be accompanied by a parent/guardian.

___A current copy of your medical insurance card is required to be seen.

My initials above and my signature below signify I have read the above and understand the counseling I have received.

We look forward to building a great relationship with you. Welcome aboard!

Patient Name_____ Parent/Guardian _____Date_____