WELCOME TO CHILDREN'S DENTISTRY OF WICHITA FALLS - Dr. Timothy D. Lee, DDS

Please initial each line below and sign by the **X** below

CONFIRM Appointments

_____ It is our sincerest hope that you join in our efforts to provide quality and prompt care for each valued child. As a courtesy, our office calls to confirm **1 week** prior to your child's scheduled appointment to ensure the date and time are still convenient for you. **Call us, anytime and leave a voicemail to confirm.** We must speak to or hear from a legal guardian or parent in order to confirm. If the insurance info is not on our forms we assume you have none, are self-pay, and will not file old claims. Update the new patient paperwork from our website and fill it out COMPLETELY. You consent to electronic reminders. Do not wait to give us the insurance info until the day of, or we will reschedule. We schedule 6 months in advance and we are booked out 3 months in the future, which makes a missed visit 9 months later.

_____ Ultimately it is the responsibility of the **legal guardian or bio parent** to keep an appointment and arrive on time. We cannot see you if you are more than 10 minutes late. We do understand children get sick and unforeseen circumstances arise. This policy is in place to ensure all child patients are able to schedule an appointment within a reasonable time frame. Call us early. We can only disclose health info to the legal guardian/parents on the paperwork.

_____ If we do not hear from you a day before the day of your child's appointment we will have no other choice but to remove your child from the schedule so we may allow someone else to take the time. **It is your responsibility to confirm your child's appointment with our office.** We will not reappoint the patient after 2 late cancellations or 2 no-shows. Not restorations are reappointed.

Avoid losing appointments

- **Confirm appointments in a timely manner @ 940-613-0210 leaving a message.**
- **Call us with any questions.**
- **Pay your overdue accounts so we can continue to see the patient of record.**
- **Update ALL insurances' info prior to making an appointment to avoid delays.**
- **Make sure we have working numbers and email addresses so we may easily contact you.**

Notice of Privacy Practice Receipt Acknowledgement: By signing below, I acknowledge that I received or have access to a copy of Timothy D Lee DDS PC Notice of Privacy Practices, in the lobby and online. I understand that I should read carefully the Notice describing how my child's health information may be used/disclosed. I am aware that it may be changed at any time and that I may obtain a revised copy in the lobby or website. I consent to autodialed or pre-recorded emailed, phoned, and texted appointment reminders to computers, mobile and/or residential phones. When you choose to opt out of text/email, please call us to confirm.

FINANCIAL RESPONSIBILITY

_____ Payment is due when services are rendered if we do not expect insurance to cover all costs associated with treatment. Down payment in advance **is** required in order to schedule restorative treatment, and full payment for hospital work. Please sign your name on the forms. Include insurance 1-800#, group#, member#.

____ **FULL PAYMENT IS EXPECTED BEFORE THE TIME OF SERVICE. We accept Cash, Cards, or Care Credit.**

BILLING: As a courtesy, your claims will be submitted to any dental insurance plan for which you provide information and in which you are currently enrolled. You will be billed for any balances considered to be the responsibility of the member after the insurance company has processed your claim. Copays, and deductibles however, are due at the time of service and will be collected by the front office staff when appropriate. As an additional courtesy, we verify your insurance coverage and benefits prior to your first visit. However, this verification is not a guarantee of payment since our office is simply calling on your behalf to obtain information. We cannot be held liable for any errors or misinformation of quotes insurance coverage or benefits. We strongly urge each patient to contact member relations of his/her insurance plan to also verify coverage, benefit limitations, and payment policies. You may pay upfront and file the claim yourself.

____ Insurance payment doesn't always coincide with our estimate of amount owed. We do our best to coordinate your benefits but all quoted estimates are not guarantees of your particular insurance reimbursement and your benefits may be different. It is your responsibility to verify all insurance reimbursement for any procedure treatment planned if you have concerns about your coverage. For example, you are responsible for any difference in cost of a more expensive procedure and for the patient portion of the EOB.

Financial & Privacy Acknowledgement: I have read, understood, and agreed the Financial Guidelines. I have had the opportunity to ask questions. I agree to accept FULL RESPONSIBILITY regardless of what insurance pays for any costs, legal, or otherwise incurred for the collection of amounts owed. Failure to pay for services rendered will result in dismissal. *Parent/Guardian Signature*

X _____ Date _____

Patient Name _____