

Appointments

******If a legal guardian/parent will not accompany the patient for an appointment, contact our office for the required authorization form******

- Cancellations

If you find that you must change your appointment, we require a minimum of 48 hours' notice so that we may make every effort to accommodate other patients. If proper notice is not received, a fee may be charged for every appointment canceled. Once an appointment is made, please remember this time is reserved for the patient. Families who miss two or more appointments without proper notification, at least 48 business hours, may be dismissed from the practice.

- Late Arrival

Your appointment was scheduled to allow for enough time to provide the best service for you. Patients who arrive for their appointments more than 10 minutes late may have to be rescheduled. If you need to be rescheduled, you may be charged a fee.

Financial

- Payment

The parent or guardian who accompanies the child is responsible for payment.

Payment is expected at time of service. If you have insurance, you may be expected to make an estimated payment for services not covered by your insurance plan. For your convenience, we offer several payment options:

*Cash

*Personal Check

* MasterCard, Visa, Discover, and American

Express

- Insurance

Dental insurance is intended to cover some, but not all of the cost of your dental care. Most plans include coinsurance provisions, a deductible, and certain other expenses which must be paid by the patient at the time of services.

Reimbursement amounts are not, and never have been, a guideline for quality care. As a courtesy to our patients, we can file most insurance claims. If you would like us to file for you, please be sure to bring all insurance plan information with you on your first visit. Our goal is to ensure that you receive the maximum benefits to which you are entitled.

Insurance PPO's and HMO's and office participation are constantly changing and updated. Children's Dental of Winona's current participation should be verified by you. This can be done by contacting your insurance plan directly. Treatment plans and fees for return appointments will be reviewed and dental procedures discussed. If you have any questions about your insurance plan, what information is required for us to file for you, please call our office at 507-452-1543.

- Billing/ Fees

Our fees are based on the time and cost required to provide our services to you and your family. We strive to use the most updated materials and technology available. We encourage you to openly discuss your questions or concerns regarding the treatment with our doctor or staff. Payment of fees are due at the time service is rendered. For multiple appointments or complex treatment, a financial agreement with monthly payments can be discussed with our financial coordinator. Our billing statements are mailed on a monthly basis and payment is expected within 30 days. Any accounts over 30 days are subject to a finance charge. Accounts will be charged a fee of \$25.00 for checks returned NSF (non sufficient funds). Contact our office if you have any concerns about your account.

I certify that I have read and understand the above information and I have answered all questions accurately and my questions have been answered to my satisfaction. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents to third party payers and/or health practitioners in connection with our healthcare operations. I authorize my insurance company to pay any benefits directly to the dentist, that are otherwise payable to me.

Signature _____

Date: _____

I acknowledge I have received (if requested) or reviewed, a copy of the office's Notice of Privacy Practices, located on our website. I understand that I can refuse to sign and that by refusing to sign, I agree to file my own insurance and pay for services on the day of treatment.

Signature _____

Date: _____

EMAIL COMPLETED FORM TO: CDOWSECURE@GMAIL.COM