DENTISTRY FOR CHILDREN
MATT W. ANDERSON, DDS, PC

FINANCIAL ARRANGEMENTS

Payment for dental treatment is expected when the services are performed. We accept cash, checks, Master Card and Visa. If you have dental insurance, you must provide us with all the information required, and we must have time to verify with your company. If for any reason, the insurance company does not cover a procedure, the full fee is the responsibility of the parent/guardian.

FINANCIAL AGREEMENT

If my account becomes past due (60 days past the date of service), I agree to pay a finance charge of 18% APR on my unpaid balance. In addition, should my account become delinquent, I will be responsible for any and all legal fees, court costs, and collection charges.

CONSENT FOR TREATMENT

State law requires us to obtain your written consent for dental treatment or surgery. Please read this form carefully and ask about anything that you do not understand.

I hereby authorize Matt W. Anderson and/or dental auxillaries of his choice, to perform upon my child or legal ward, dental treatment or oral surgery procedure(s), including the use of any local anesthesia, radiographs (x-rays), or diagnostic aids.

In general terms, the dental procedure(s) or operation may include:

- Examination, cleaning of the teeth, and application of topical fluoride
- Use of physical restraint or restraint devices to safely accomplish the necessary dental procedure(s)
- Application of resin “sealants” to grooves of the teeth
- Treatment of diseased (decayed) or injured teeth with restoration (fillings or crowns)
- Removal (extraction) of one or more teeth
- Replacement of missing teeth with dental prosthesis
- Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities
- Use of sedative drugs to control pain, gagging, apprehension, and/or disruptive behavior
- Use of general anesthesia to accomplish the necessary treatment

Although their occurrence is extremely rare, some risks have been reported to be associated with dental procedures and/or oral surgery procedures. State law requires us to mention the possible risk of numbness, bruising, discoloration, nausea, vomiting, allergic or drug reaction, brain damage, stroke, heart attack, aspiration, or swallowing of a foreign object or scars associated with procedures. I further understand and accept that complications may require hospitalization and may even result in death.

I hereby state that I have read and understand this content, and that all questions I had were answered to my satisfaction. I understand I have the right to be provided with answers to questions which may arise during the course of the child’s treatment.

BROKEN APPOINTMENT POLICY

We require at least 24 hours’ notice if you cannot make the appointment that has been reserved for your child. This gives the office staff ample time to fill that appointment. We reserve the right to charge a $35.00 broken appointment fee (emergencies are an exception), if the 24 hours’ notice is not given. More than one missed appointment will be grounds for dismissal for our practice.

I, ____, the legal guardian/parent of ___________________________________ have read and understand the above office policies and will be held accountable for all of the above.

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PARENT/GUARDIAN SIGNATURE **DATE**