



FINANCIAL AGREEMENTS

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

Accounts that become past due (60 days from the date of service) will be subject to a finance charge of 18% APR on the unpaid balance. In the event the account becomes delinquent and is referred for collection, the parent/guardian agrees to be responsible for all costs incurred, including but not limited to legal fees, court costs, and collection expenses. Accounts sent to collections will be dismissed from the practice.

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.

Upon consenting for dental treatment, I authorize Matt W. Anderson, DDS and/or dental auxiliaries 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) 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). Use of restraint is rare, in the event it is needed, additional parental consent will be obtained
- 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
- Use of sedative drugs (Nitrous Oxide) to control pain, gagging, apprehension, and/or disruptive behavior
- Use of general anesthesia to accomplish the necessary treatment will be completed in a hospital or surgery center setting

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.

CANCELLATION AND LATE ARRIVAL POLICY

We require at least **24 hours' notice** if you need to cancel or reschedule an appointment. This allows our office the opportunity to offer the time to another patient.

- Appointments cancelled with less than 24 hours' notice, or missed appointments (no-shows), may be charged a broken appointment fee of **\$60 for hygiene appointments** and **up to \$100 for operative appointments**.
- Repeated missed appointments will result in dismissal from the practice.
- Appointments are scheduled to allow adequate time to provide quality care. Patients who arrive **more than 10 minutes late** may need to be rescheduled and may be subject to the same fee structure: \$60 for hygiene appointments and up to \$100 for operative appointments.
- A no-show or short-notice cancellation for **new patient appointments** will result in the appointment not being rescheduled.

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

PARENT/GUARDIAN SIGNATURE

DATE