Office Policy & Patient Consent for Minors

Thank you for choosing Nolensville Pediatric Dentistry, PLLC as your child's dental care provider. Our dental health team is committed to excellence in dental care in a friendly, comfortable environment. It is very important to us as your dental care provider to utilize every means necessary to provide the best dental care possible. We ask that when you have an appointment, please call and confirm the appointment to ensure that we will still have availability. Unconfirmed appointments are not guaranteed and can be given away in the case of an emergency. Confirmed appointments can be counted against you if the appointment is not kept or if we are not notified within 24 hours of the appointment.

The courtesy of a two day notice is appreciated should you need to cancel or reschedule your child's appointment. A $50 cancellation fee will be assessed for missed appointments without 24 hour notice. After 3 missed appointments, you may be asked to find another provider.

Insurance

At NPD, PLLC, we are not contracted with all insurance companies. It is your responsibility to make certain your insurance plan will pay for your visit. Of course we will be happy to assist you; however, please understand that your insurance policy is a contract between you and your insurance company. We are a third party and have limited ability to act on your behalf; therefore, we do not guarantee insurance benefits. Estimated co-pays will be due at the time of service.

Upon signature of this policy and consent form, you authorize the practice to release to staff, hospitals, healthcare service plans, insurance companies, self-insurers or the representatives, any and all information, records, and radiographs regarding the patient's medical history, services rendered, or recommended treatment. You also authorize the practice to submit claims electronically and/or manually for payment for services rendered, or pre-authorizations deemed necessary by your insurance company. When such claims are submitted to the insurance company or third party on your behalf or the patient's behalf, your name will be listed as "Signature On File" and will assign to the practice the insurance benefits, providing assignment is accepted. You are responsible for payment regardless of the coverage provided.

Any account not paid in full within 60 days will be subject to collection fees. The fees incurred will be the responsibility of the parents and/or legal guardians. These fees may include, but are not limited to, returned check fees, attorney fees, and court costs.

TennCare Patients: Most procedures are covered by TennCare. Payment for procedures not covered (or claims denied due to ineligibility) by TennCare are the responsibility of the parents and/or legal guardians. It is your responsibility to make certain your TennCare coverage is in force prior to your appointment.

Clinical Consent

As the parent/legal guardian of the minor patient(s), I authorize the associates of Nolensville Pediatric Dentistry, PLLC to perform all recommended treatment on the patient(s).

I authorize the associates of Nolensville Pediatric Dentistry, PLLC to take radiographs, study models, photos, and other diagnostic aids or materials collectively ("diagnosed material") as needed to make a thorough diagnosis. I authorize that such diagnostic material may be released to third-party payers and/or other healthcare professionals.

I have read the Patient Consent and agree to the terms and conditions herein.

Patient Name(s): ______________________________ D.O.B(s): ____________________

Signature of Parent/Legal Guardian: ____________________________ Date: ______________

Relationship to Patient: __________________ Address: ______________________________