Flanders Pediatric Dentistry

Consent to Treat Form

Child's Name:______________________________ **D.O.B.**__________________

As my child/ children's parent or guardian, I give authorization for the following people, who I have placed the care of my child(ren) to sign consent for dental treatment should they bring my child(ren) to future appointments. I understand that all routine dental visits can include but are not limited to: an oral examination, radiographs, cleaning of the teeth and the application of topical fluoride.

Person's Name:	**Relation:**
______________________________________	_________________________
______________________________________	_________________________
______________________________________	_________________________

*** I understand that I will send a note with any medical changes and consent/denial for x-rays to any appointment that I do not personally attend***

______________________________________ _________________________

Parent/ Guardian Signature Date

Flanders Pediatric Dentistry

Consent for Use of Behavioral Techniques

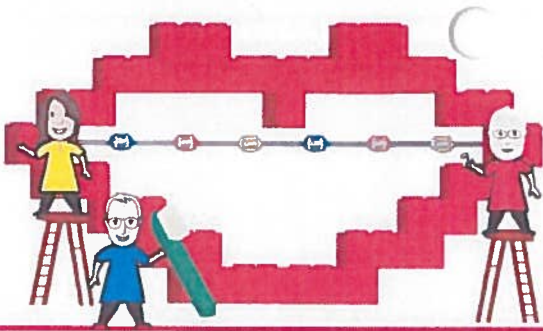
In managing your child(s) visit, it may be necessary to use behavior management techniques to improve behavior. These techniques could include, but are not limited to:

1. Voice Control
2. Tell, Show, Do
3. Modeling
4. Behavior Modification
5. Separation
6. Systematic Desensitization
7. Nitrous Oxide Administration

Utilizing these techniques should enable us to provide your child with optimal dental care. There are times where we will ask you to be an active participant in your child(s) visit. If you or your children have any questions or concerns, please do not hesitate asking the doctor at the time of the visit.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND ALL OF MY QUESTIONS WERE ANSWERED.

Signature of parent or guardian: ______________________________ Date: _____________



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Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Flanders Pediatric Dentistry, LLC to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Flanders Pediatric Dentistry, LLC health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I do not sign this form, Flanders Pediatric Dentistry, LLC; may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.

- Flanders Pediatric Dentistry, LLC **DOES NOT** email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Flanders Pediatric Dentistry, LLC; already sent before receiving my written instruction to stop.

Patient Name (please print):____

☐ I decline to give consent

Signature:____________________________________ Date:____________________

Patients Name: ______________________

Payment Agreement

PAYMENT IS EXPECTED ON THE DAY THAT SERVICES ARE RENDERED.

Payment Options: CASH, CHECK, CREDIT CARD (Visa, Mastercard, Amex, Discover), or CARE CREDIT

Missed Appointments:

Appointment times are reserved especially for you. If for any reason you should need to change your appointment, please contact our office as soon as possible. **We reserve the right to charge a $50 fee for cancellations made with less than 24 hours notice and for broken/ no show appointments.** As a courtesy to you, our office makes every effort to confirm your scheduled appointments via phone, text, and email. If for some reason you do not receive a confirmation, you are still responsible for maintaining your appointment times.

Insurance Submission:

We participate with the following insurance companies and will honor their contracted fees: **Delta Dental Premier, Guardian, Cigna PPO, MetLife, Aetna PPO Access II, Assurant and DHA Affiliated Plans, United Concordia Alliance Network and Horizon BCBS Dental Option and Traditional.**

We will happily assist you in completing and submitting your insurance claim. You must provide us with all insurance and subscriber information. If this information is unavailable, please understand that full payment will be collected at the time of each visit and then the claim will be submitted to your insurance company once all of the necessary information is received. Any overpayment will be refunded to you.

Submission of insurance and acceptance of assignment of benefits is not a guarantee of payment. We encourage all of our patients to contact their insurance carrier directly to obtain a more accurate estimate of what insurance intends to pay. While we do our best to give you accurate estimates regarding your patient portion, please realize we do not receive advanced notification when your employer or insurance company makes changes to your coverage. **It is important for you to know what your insurance covers, as every policy is different.** Many insurance companies are now only covering fluoride one time per year.

Although we will wait for your insurance to pay their portion, your estimated portion is expected at the time of service. In addition, should your insurance deny payment or pay less than estimated, we request that you pay for the services in full within 90 days.

I HAVE READ THE ABOVE POLICY AND FULLY UNDERSTAND MY RESPONSIBILITY.

Signature: ______________________ Date: ______________