TO OUR PATIENTS AND FAMILIES

Thank you for choosing Little Rockies Pediatric Dentistry (LRPD) for your child's dental care. We consider families to be an essential participant in your child's care and wish to support and respect your needs while your child is under our care. We want you to understand your rights and responsibilities as families and patients at LRPD. Your signature on this form provides consent for treatment and payment, and acknowledges receipt of other general information.
If you have questions, please ask your provider.

Consent for Treatment
I hereby authorize and request the performance of dental services for my minor child. I understand that at the first appointment (examination, necessary x-rays, cleaning, topical fluoride) the doctor will explain my child's treatment needs and the various behavior management approaches. At this appointment the doctor's staff will review any associated fees. I also realize that any restorative treatment will be accomplished at a later date.

Missed/Broken Appointment Policy
Due to the limited space in our schedule and the need to provide timely service to all of our patients it is very important that you keep your scheduled appointments. It is understandable that occasionally you may need to reschedule due to an emergency or illness. We ask that you give us the courtesy of a 24 hour notice so that we will have the opportunity to use your appointed time to provide treatment for others in need. If you cancel your appointment without 24 hour notice or if you "No-Show" for your appointment, then you will be required to a pay a **$75.00 Non-Refundable Fee**.

Assignment of Benefits (AoB) and Release of Information (RoI)

- I consent to and authorize that payment of benefits for healthcare related services be made to LRPD. This consent specifically authorizes LRPD to release Protected Health Information (PHI) to insurers, governmental agencies and their agents for billing purposes and determination of benefits.
- I assign any benefits payable for provider services to the provider or organization providing the services.
- **I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of LRPD and of providers rendering services not otherwise paid by my health insurance or other payer. All charges due are payable upon receipt of the bill. If payment is not made within 60 days after receipt of bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for any debt collection.**
- The terms of this AoB and RoI will be until final payments are made for all services.
- If and when there are any changes to my insurance plans, I will notify CSPD staff and sign a new agreement.

_____ _____
Print Patient's Name Date

_____ _____
Signature Print your name

_____
Relationship to Patient

_____ _____
Guarantor Address City/State/Zip

Little Rockies Pediatric Dentistry
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