R. James Richardson II M.S., D.D.S., Inc.
Pediatric Dentistry

Patient Name: _____

FINANCIAL POLICIES

Insurance Form Billing:

- As a courtesy to all our patients, we will bill your insurance company directly.
- Some insurance companies select certain procedures for which they will not provide payment. It is the patient's responsibility to be familiar with our individual insurance policy so you understand the financial obligation related to your treatment.
- It is our intent to provide you with the most accurate co-payment information; however, ALL co-payment fees quoted are ESTIMATES ONLY. Estimated co-payments or patient responsibility portions are due at the time of the appointment, unless previous arrangements have been made with the treatment coordinator.
- I agree to the "Assignment of Benefits" portion of the insurance form, therefore instructing my insurance company to send payment directly to the office on my behalf. Should the insurance mail payment directly to me, payment is expected to be forwarded to the office within 5 days.

Initial: _____ Date: _____

Return Check Policy:

- A returned check fee of $30.00 will be charged for all checks returned due to insufficient funds. Cash, cashier's check, or money order will be required to replace the dishonored check.

Initial: _____ Date: _____

In order to better serve you, Dr. Richardson and Team would appreciate your cooperation and involvement in the following areas:

1. **Appointments:** It is important that you are consistent and punctual with your appointments.
2. **Cancellations:** If you are unable to keep a scheduled appointment, we require a 24 hr notice prior to the appointment time. We can then reschedule according to your needs, while leaving necessary time to schedule someone else into your appointment slot. Our office has an answering system and voicemail service for your convenience. If less than 24hr notice is given or you fail your appointment, there will be a $50 fee per appointment/per child.
3. **Failed Appointments:** If no notice is given, a failed appointment will be charged the $50 fee. For multiple failed appointment, and in special cases when the doctor must make extraordinary preparations for your appointment, the full fee amount of the treatment scheduled will be charged to your account as a failed appointment fee. Or, the full fee will be due and need to be prepaid before we reschedule your appointment.

Initial: _____ Date: _____

PATIENT INFORMATION EMAIL AND TEXT RELEASE

For your convenience our office can email or text confirmation of your appointment, treatment plan or account information.

Unencrypted email/text is not a secure form of communication. There is some risk that any individual identifiable health information, which may be contained in such email/text, may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email/text from us regarding your appointment or treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify you agree to sign up for email notifications and also be able to turn on or off text message notifications inside your own www.babyteethdoc.com account. (Individual texting rates may apply).

Check boxes for each statement that applies:

☐ I consent and accept the risk receiving information via email. I understand I can withdraw my consent at any time.

My email address is: _____

☐ I consent to receiving appointment reminders via text. I understand I can withdraw my consent at any time.

My cell phone number is: ( ) _____-_____

☐ I DO NOT consent to receiving any information via email or text. I understand that I can change my mind and provide consent at a later time.

OFFICE POLICIES AND FINANCIAL AGREEMENT

I, _____, understand and agree with all of the office and financial policies described by R. James Richardson II, M.S., D.D.S., Inc. I further understand that my insurance policy is a contract between my insurance company, my employer and myself; wherein I have requested the insurance company make payment directly to R. James Richardson II MS DDS INC for my family's dental treatment. I am fully aware that ultimately, I am responsible for all required payments to Dr. Richardson for my family's dental treatment. I also acknowledge receipt of HIPPA (Health Insurance Portability and Accountability Act) and "The Facts About Fillings" material data sheet upon completion of my child's initial exam.

Patient Name: _____ (print)

Parent Signature: _____ Date: _____