NOTICE TO PARENTS / GUARDIANS

★ We feel fortunate to be able to provide your child with pediatric specialty services.

★ Each child entrusted to our care receives individualized attention and treatment.

★ Our Team Goal is to provide an EXCELLENT service experience for you and your child to build our practice with happy, satisfied and loyal families.

With mutual respect and cooperation we seek to maintain this ideal.

BROKEN APPOINTMENTS

- ✓ **We reserve Dr. Warren's time for your child, at your request and commitment**. We need at least **2 business days notice** of any requested changes to allow others the opportunity to schedule in your place. **SAME BUSINESS DAY* CANCELLATIONS will result in a** $**25 CHARGE** per child.
- ✓ **NO CALL NO SHOW will result in a $50 CHARGE** per child**.**

  * messages after hours are received the following business day. INITIALS _____

- ✓ If your child is scheduled for treatment with ***Oral Conscious Sedation***, we reserve 1 ½ hours and require **2 BUSINESS DAYS** advance notice of changes. **SAME BUSINESS DAY CANCELLATION will result in a $100 CHARGE.**

INITIALS _____

PAYMENT FOR SERVICES

We are IN NETWORK providers for most dental plans. We work hard to acquire the comprehensive benefit information of your plan. ALL plans disclaim that "the information provided is not a guarantee of payment".
We provide dental care based on the needs of your child, and your consent.
Charges stated as "your responsibility" by your insurance - are YOUR REPONSIBILITY.

INITIALS _____

OUTSTANDING BALANCES

Outstanding balances ***not paid*** *within 30* ***days*** *of your STATEMENT OF BALANCE DUE- or arrangements made with the Manager - a nonrefundable* ***late fee of $15.00*** *will be charged. If the balance is* ***not paid*** *within* ***60 days*** *an* ***additional late fee of $15.00*** *will be charged. If you ignore and refuse to pay, your account will be turned over* ***FOR COLLECTION with a 50% charge of your balance added for COLLECTION SERVICES*** *PLEASE DON'T DEFAULT ON YOUR ACCOUNT, if you do, you agree to pay collection costs and reasonable attorney fees incurred in attempting to collect YOUR account balance.*

INITIALS_____

I have read the above statements and agree to the terms and conditions therein.

Signature_____Relationship_____Date_____

Patient's Name(s)_____