



### OFFICE POLICIES

I understand Pediatric Dentistry of Shreveport-Bossier requires at least 48-hours notice for any cancelled appointment. Failure to give notice will result in a \$50.00 office charge.

I understand that all returned checks will result in a \$50.00 office charge.

I understand that the estimate I am given on my insurance is just an estimate and not a guarantee of payment from the insurance company. If my insurance pays more than expected, it will be credited to my account. If it pays less than expected, I am responsible for the remaining balance.

I assign dental benefit payments to be paid directly to Pediatric Dentistry of Shreveport-Bossier from my insurance company (unless my insurance is BCBS LA).

I understand that I am responsible for the estimated portion not covered by my dental insurance at the time the services are rendered.

I understand that collection fees will be assessed if my account becomes a collection problem.

I give permission for my dentist and his clinical team to take any necessary x-rays or photos to enable complete diagnosis and treatment regardless of what the insurance pays. The practicing pediatric dentists at Pediatric Dentistry of Shreveport-Bossier will not allow my insurance company to determine his diagnosis for my child.

I understand that food and drinks are not allowed in the office. This not only assists in the maintenance of our facility but is also a courtesy to our fasting patients.

I understand that the use of cell phones is prohibited (not allowed) in any area of the office other than the front patient waiting room. I understand that if I am using my cell phone in any area of the office other than the front patient waiting room I will be asked to put my phone away.

Signature \_\_\_\_\_ Date \_\_\_\_\_

