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Pediatric New Patient Consent

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At Icon Pediatric Dentistry, your health is our highest priority. Treatment recommendations are based on your individual needs, not on your insurance coverage. Our fees are determined by the services provided. After an evaluation with one of our Pedodontists, you and your doctor will decide on the best treatment plan for your care.

We accept most dental insurance plans; however, we are only in-network with a select few. Some policies may not provide out-of-network benefits, and some plans reimburse according to fee schedules that differ from our actual fees. We will file claims on your behalf as a courtesy, but your insurance policy is an agreement between you and your insurance provider. It is your responsibility to understand your coverage, including copayments, deductibles, limitations, and exclusions. Any claim balances unpaid after 90 days will become your responsibility and must be paid in full.

By accepting treatment, the patient or guardian assumes full financial responsibility for all associated fees. For surgical procedures, 50 percent of the estimated copayment is due at the time of scheduling, and the remaining balance is due on the day of surgery. Payment is due at the time of service unless other arrangements have been made in advance. Accounts unpaid after 90 days will incur a 1.5 percent monthly service charge. Accounts referred to collections will be subject to attorney fees and additional collection costs. We accept payment by cash, check, Visa, MasterCard, Discover, American Express, and Care Credit. A $35 fee applies to all returned checks. We recognize that each patient's financial situation is unique and will work with you to explore payment options.

Due to the preparation involved in most procedures, we require 48 business hours' notice for cancellations. Failure to provide notice will result in a cancellation fee of $50 for hygiene appointments and $150 for surgical appointments.

I consent to being photographed for purposes related to my dental care, including records, education, patient counseling, and professional use.

I understand that healthcare providers may be exposed to my blood or body fluids during treatment. If such exposure occurs, I consent to mandatory testing. Results will be shared with me and any involved providers.

We are committed to protecting your health information in compliance with federal and state laws. This notice outlines how your information may be used and disclosed, and your rights regarding that information. Our privacy practices took effect November 1, 2004, and remain in effect until updated. We reserve the right to revise them as permitted by law.

Your health information may be shared with other healthcare providers involved in your care, used to obtain payment for services, and used for quality assurance, training, accreditation, and related activities. You consent to being contacted by phone, text, or other communication methods regarding appointments. With your consent, we may share health information with family or others involved in your care. We may also disclose information as required by law or for public safety.

You have the right to request copies of your health information. You may request limitations on how your information is used, though we are not required to agree. You may request that information be sent in an alternate format or location. You may request corrections to your health information, though requests may be denied under certain circumstances.

If you have questions or concerns about our privacy practices, or wish to file a complaint, please contact our office. You may also file a complaint directly with the U.S. Department of Health and Human Services.

I acknowledge that I have read and understand the above consent, financial agreement, and privacy practices, and I agree to the terms

Signature