WELCOME TO CHILDREN'S DENTISTRY OF WICHITA FALLS - Dr. Timothy D. Lee, DDS
Please initial each line below and sign by the **X** below

CONFIRM APPOINTMENTS

x_____ It is our sincerest hope that you join in our efforts to provide quality and prompt care for each valued child. There will be absolutely NO charge for your need to reschedule an appointment if you give us **24-hour notice** for **hygiene** and **48-**hour notice for **treatment** appointments. As a courtesy, front office calls to confirm **2 days** prior to your child's scheduled appointment to ensure the date and time are still convenient for you. Call us. You may reply to our texts and emails to confirm your child's appointments. You will receive an **email/text 1 week** before the scheduled appointment, then an email/text **2 days before**, and lastly a courtesy email/text is delivered **2 hours prior**. You may choose to opt in/out of that service, but if opted out, we must speak to a legal guardian or parent in order to confirm.

x_____ Ultimately it is the responsibility of the legal guardian or parent to keep an appointment and arrive on time. We cannot see you if you are more than 10 minutes late. We do understand children get sick and unforeseen circumstances arise. This policy is in place to ensure all child patients are able to schedule an appointment within a reasonable time frame. Call us early.

x_____ If we do not hear from you by the day of your child's appointment we will have no other choice but to remove your child from the schedule so we may allow someone else to take the time. **It is your responsibility to confirm your child's appointment with our office.** We will not reappoint the patient after 2 late cancellations or 2 no-shows.

Avoid losing appointments

- **Confirm appointments in a timely manner @ 940-613-0210 leaving a message or replying to the text or appointment_cdwf@sw.rr.com.**
- **Give us at least 24/ 48 hours advanced notice to cancel or reschedule an appointment.**
- **Call us with any questions.**
- **Overdue accounts will no longer be considered patients of record unless payment is made.**
- **Update all insurance info prior to making an appointment to avoid delays.**
- **Make sure we have working numbers and email addresses so we may easily contact you.**

Notice of Privacy Practice Receipt Acknowledgement: By signing below, I acknowledge that I received or have access to a copy of Timothy D Lee DDS PC Notice of Privacy Practices, in the lobby and online. I understand that I should read carefully the Notice describing how my child's health information may be used/disclosed. I am aware that it may be changed at any time and that I may obtain a revised copy in the lobby or website. I consent to autodialed or pre-recorded emailed, phoned, and texted appointment reminders to computers, mobile and/or residential phones.

FINANCIAL RESPONSIBILITY

x_____ Payment is due when services are rendered if we do not expect insurance to cover all costs associated with treatment. Down payment in advance **is** required to schedule any restorative treatment. If you do not have insurance to file, you are required to pay the down payment of the estimated treatment plan charges in order to schedule your child's next appointment and pay the remainder at time of service.

x_____ **FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. We accept Cash, Check, and credit cards, or Care Credit. A $30.00 CHARGE WILL BE ASSESSED FOR ALL RETURNED CHECKS.**

BILLING: As a courtesy, your claims will be submitted to any dental insurance plan for which you provide information and in which you are currently enrolled. You will be billed for any balances considered to be the responsibility of the member after the insurance company has processed your claim. Copays, and deductibles however, are due at the time of service and will be collected by the front office staff when appropriate. As an additional courtesy, we verify your insurance coverage and benefits prior to your first visit. However, this verification is not a guarantee of payment since our office is simply calling on your behalf to obtain information. We cannot be held liable for any errors or misinformation of quotes insurance coverage or benefits. We strongly urge each patient to contact member relations of his/her insurance plan to also verify coverage, benefit limitations, and payment policies. You may pay upfront and file the claim yourself.

x_____ Insurance payment doesn't always coincide with our estimate of amount owed. We do our best to coordinate your benefits but all quoted estimates are not guarantees of your particular insurance reimbursement and your benefits may be different. It is your responsibility to verify all insurance reimbursement for any procedure treatment planned if you have concerns about your coverage. For example, you are responsible for any difference in cost of a more expensive procedure.

Financial & Privacy Acknowledgement: I have read, understood, and agreed the Financial Guidelines. I have had the opportunity to ask questions. I agree to accept FULL RESPONSIBILITY regardless of what insurance pays for any costs, legal, or otherwise incurred for the collection of amounts owed. Failure to pay for services rendered will result in dismissal. *Parent/Guardian Signature*

X _____ Date _____