Children's DENTAL CENTRE

Kaitlin J Hoogeveen, DDS
164 South Main Avenue • PO Box 228
Sioux Center, IA 51250 • PH: 712.722.5565
childrensdentalcentresc.com

OFFICE POLICIES & AGREEMENTS

PARENTAL AGREEMENT

Parents are welcome to accompany their child into the treatment area during the initial examination. This gives you the opportunity to see our dental team in action and gives the doctor an opportunity to discuss dental findings and treatment needs directly with you. We do ask that if you accompany your child you assume the role of ***a silent observer***. Your presence is greatly enhanced, if you play a passive role. If more than one person is speaking to the child, they may become confused. Cooperation and trust must be established directly between the doctor and staff and your child, not through you.

At subsequent ***REGULAR CHECK-UP*** appointments, we encourage children to come back to the treatment area by themselves, as this builds autonomy and trust. We do, however, have an "open door policy" for cleanings and check-up appointments. As their parent/caregiver, you are more than welcome to come back during your child's cleaning and check-up. Again, we ask that you do this as ***a silent observer***. Children who are very apprehensive may look for an "escape" or put on an "act" for their parent(s). If this is the case, we ask that you respect Dr. Kaitlin's professional opinion. If she decides that the child/individual would benefit from having you remain or return to the waiting room, please respect our request and leave silently and immediately.

At ***TREATMENT APPOINTMENTS,*** parents must remain in the waiting room. Your child is having an operative procedure on his/her teeth, and it is our goal to do our work at the highest quality and put your child's needs first. In order to do that, we require parents to remain in the waiting room so that we are able to focus solely on your child's needs and not the needs or anxieties of the parent. The door will either be open if one assistant/doctor is present or there will be two personnel present at all times with your child if the door is closed. Our goal is to facilitate a more open line of communication between the child and the doctor, and we feel this is best achieved when the parent is not present in the treatment room.

The following is a brief explanation of some of the methods we use to guide your child's behavior and provide a positive dental experience. These techniques are based on scientific principles from the American Academy of Pediatric Dentistry. Since each child is unique, no list can be entirely comprehensive and other methods may therefore be explained as needed.

Tell, Show, Do: This is the most important tool for teaching your child. Your child will be told in simple terms what will be done. Next we will show them and then the procedure is performed.

Imagery: We tell children in simple, playful terms what is going to be done. For example, a dental exam becomes "looking and counting teeth." We encourage you to use these terms when talking to your child about their dental experience(s). We never use the words shot, needle, etc.; but instead use sleepy water and put teeth to sleep.

Distraction: Sometimes it is necessary to distract your child from an unpleasant sensation by focusing his/her thoughts on something other than what is being done.

Positive Reinforcement: This is a technique used to reinforce good behavior by praising your child or providing a reward following a desired response in hopes of promoting continued good behavior.

Non-Verbal Communication: Behavior is guided through appropriate contact, posture, and facial expression.

Parental Presence or Absence: This technique uses the presence or absence of a parent in the room to gain cooperation and compliance. Typically, the parent is asked to leave the room to enhance the communication between the dentist and child. Once cooperation improves, a parent may be asked to return to the room as a reward for good behavior.

Voice Control: Voice control is a controlled change of voice volume, tone or pace to influence and direct the child's behavior. This technique is used to redirect behavior, establish clear expectations and establish a line of communication between our doctor and your child.

→ ☐ **I have read and agree to the "Parental Agreement" as written above.**

Parent (Guardian) Initials: _____

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Your appointment: Please make every effort to arrive on time to your appointment. We will contact you 48 hours before your appointment to confirm. Telephone voicemail and email are available if you are unavailable at the time of our call. We specifically reserve the required amount of time for your child's planned treatment. If you arrive more than 15 minutes late, your child's appointment may need to be rescheduled or all planned treatment may not be able to be completed at that visit.

Communication/Correspondence: Our office will contact you regarding appointments, treatment, billing information and other dental health related information via cellular/home/work phone confirmations, text messages, emails and/or US mail/postcards.

Cancellation/Reschedule: Should you need to reschedule your child's appointment, we request a 48 hour notice with a minimum of 24-hour advanced notice. We certainly understand that cancellations on short notice due to emergencies and last minute developments may arise and can happen to all of us. However, the lack of reasonable, advanced notice result in lost opportunities to serve others.

Failed appointment policy: If a patient arrives more than 15 minutes late, fails, or cancels scheduled appointments without 24 hours advanced notice on two (2) separate occasions, your family will be dismissed from our practice. If an initial examination is failed, you will be unable to reschedule.

Statements: We send monthly statements on all open account balances, so that you are aware of what credits and payments have been made to your account. Unless specific arrangements have been made with our Business Manager all accounts over 90 days will be referred to an outside collection agency. There is a $50 charge to all accounts that are sent to collections.

→ ☐ **I have read and agree to the "Office Policies" as written above.** **Parent (Guardian) Initials: _____**

FINANCIAL POLICY

A clear understanding between all of us will help ensure that our main concern is with your child's dental care, rather than pending excessive time collecting payment from an insurance company.

Payment is required at the time services are rendered: We will make our best effort to accurately estimate the amount of payment due at your initial or recall appointment based on your insurance policy's deductible, co-pay, co-insurance and out of pocket maximum of covered services. ***This payment is due the day services are provided.*** After a patients initial/recall examination, any treatment deemed necessary will be submitted to your insurance for a "pre-treatment estimate." ***You will be responsible to pay this amount, in full, when appointments occur and treatment is provided.*** In some cases, insurance companies use outdated fee schedules or require a larger co-pay; therefore, it is not possible to give you a completely accurate estimate. Because of this, it is possible that you will owe more on your child's account or receive a credit to their account, which is determined after the insurance claim is received back to our office. If more money is owed, you will be sent a bill that you are expected to pay within 30 days. If the estimate is greater than the amount paid, your child/family's account will be credited the difference, unless other arrangements have been made with our Business Manager. All accounts with an open balance for over 90 days will be sent to an outside collection agency. There is a $50 charge to all accounts that are sent to collections.

We are happy to file your insurance as a courtesy to you: Keep in mind your insurance policy is a contract between you and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. We will accept assignment of benefits from your insurance company; however, you are responsible for the full balance including any amount that is not covered by your insurance company. If the insurance company does not process the claim within 45 days of submission, you will be responsible for the balance.

If you would like us to file your insurance claim for you, please provide our office with a copy of your current insurance identification card for each visit: We must be able to confirm with your insurance company that they can assign benefit payment to our office. If an insurance company cannot confirm assignment of benefits, you will be required to pay for all services at the time they are rendered.

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We are currently preferred providers (in-network) for the following companies: Delta Dental and Wellmark Blue Cross and Blue Shield (Blue Dental). We are considered out-of-network for all other insurance companies at this time.

→ ☐ **I have read, understand and agree to the foregoing Financial Policy. I authorize Dr. Kaitlin J Hoogeveen to release any information, including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers, I have read and understand my obligations and acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier. I authorize and request my insurance company to pay directly to Children's Dental Centre/Dr. Kaitlin J Hoogeveen insurance benefits otherwise payable to me. I authorize and request Dr. Kaitlin J Hoogeveen to use my signature on file for my signature on all dental insurance forms to expedite computer processing of my claims.**

Parent (Guardian) Initials: _____

CONSENT FOR DENTAL TREATMENT

I understand that the information (e.g. health history, insurance information, etc.) I have given is correct to the best of my knowledge and that it will be held in strict confidence by Children's Dental Centre. It is my responsibility to inform this office of any changes in my child's medical and insurance status.

I request and authorize Dr. Kaitlin J Hoogeveen to examine, clean and provide dental treatment on my child's teeth. I further request and authorize the taking of dental radiographs (x-rays) considered necessary by Dr. Kaitlin J Hoogeveen to diagnose and/or treat my child's dental problem(s). I will allow photographs to be taken of my child and/or child's teeth for diagnostic or educational purposes.

I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Kaitlin J Hoogeveen will provide an environment likely to help children/individuals learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone to direct the patient's behavior.

→ ☐ **I have read and agree to the "Consent for Dental Treatment" as written above.** **Parent (Guardian) Initials: _____**

I acknowledge I have read, understand, and agree to Children's Dental Centre's Parental Agreement, Office Policies, Financial Policy and Consent to Dental Treatment as listed above, effective for the children/individuals listed below:

Patient's Name:_____**DOB:**_____/_____/_____

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Patient's Name:_____**DOB:**_____/_____/_____

Patient's Name:_____**DOB:**_____/_____/_____

_____ _____

Signature of Parent/Legal Guardian **Date**