The Smile Team
PEDIATRIC DENTISTRY

APPOINTMENT POLICY

The Smile Team strives to provide you with exceptional, comfortable care in a timely manner. When scheduling your appointment, we reserve that time to treat your child. There is significant preparation and allocation of resources that go into each appointment, but we strive to keep costs affordable. One way we do that is through the efficient use of supplies and a professional team. Missed or broken appointments represent a cost to us, to you and to other patients who could have been seen on the time set aside for you. Automated reminders and courtesy calls from our team are a tool to help avoid missing appointments, however failure to receive one of these reminders is not an acceptable reason for missing an appointment.

We understand that unanticipated events occur in everyone's life: however, we ask you to review the following appointment policies:

Cancellation Policy

Cancellation or rescheduling of an appointment must be made 2 full business days prior to your appointment date. This allows other patients awaiting treatment to be rescheduled into the time initially reserved for you. Short notice cancellations are subject to a fee of $100.00.

No Show Policy

If a patient does not show up for a scheduled appointment the patient will be automatically charged a $100.00 fee and will be required to pay a deposit to reserve another appointment time.

Late Policy

If arriving more than 15 minutes late for a scheduled appointment, our doctors and hygienists will do their best to be accommodating: however, at their discretion, treatment scheduled for that appointment may have to be shortened and/or rescheduled for another time.

I understand the Appointment Policy as set out above.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

The Smile Team
PEDIATRIC DENTISTRY

GENERAL CONSENT FOR TREATMENT

Authorization for Care and Treatment

I hereby agree that team members at The Smile Team may perform care and treatment and may conduct such examinations, laboratory tests, and procedures, administer such local anaesthetics, medication and treatment, as may be directed by my child's dentist or treating practitioner. I acknowledge that no guarantee has been made to me as to the effect of such examinations, tests, procedures, or treatment of my child's condition.

Consent to Use and Disclose

I consent to the use and disclosure of my Protected Health Information by The Smile Team for purposes of treatment, payment, and health care operations. For example, my treating practitioner may furnish Protected Health Information maintained by The Smile Team in the course of my child's care and treatment. I understand that The Smile Team may release medical information to a third party, including my employer, which may be responsible for payment of my dental expenses. (Release of medical information to employers is limited to those employers who are directly liable for the cost of the patient's dental care benefits through an employer, self-insured group health plan, or in other circumstances in which such disclosure is legally allowed.)

Insurance Authorization

I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain procedures in order for my insurance company to pay for those services. I also understand that I am personally responsible for payment and it is my responsibility to ensure reimbursement from my insurance company.

Financial Agreement

In consideration for services rendered by The Smile Team, I guarantee prompt payment of all such services at the time services are provided. If The Smile Team does not receive payment within 30 days from the date such balance is due, the bill may be turned over to an attorney or a collection agency and, if so, I agree to pay all reasonable collections costs including attorney's fees and/or collection fees in addition to the payment owed. I give The Smile Team the right to examine my consumer credit report for information relating to my responsibility to pay for dental services.

I have read all of the above statements and accept the terms and conditions as stated.

Parent/Guardian's Name: _____

Parent/Guardian Signature: _____

The Smile Team
PEDIATRIC DENTISTRY

Privacy Policy

We are committed to protecting the privacy of our patient's personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. Fine below, a summary of the personal information we collect, use and disclose.

We collect information from our patients such as names, addresses, phone numbers, and e-mail addresses (collectively referred to as "Contact Information") for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further examination or treatment.
- To send patients informational material about our office, dental materials and services.
- To follow up with treatment and/or customer service.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment and has ashed us to submit a claim on their behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition and dental treatments. (Collectively referred to as "Medical Information"). Patient's Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. Patient's Medical Information is disclosed for the following purposes:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment, or the patient has asked us to submit a claim on their behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining a second opinion.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians, if it is a physician of the patient, with their consent, or has been referred by us to the other health care professional for either a second opinion or treatment.

If we ever consider selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process, to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all patient's personal information.

Dentists are regulated by the Alberta Dental Association and College, which in the public interest may inspect our records and interview our team as part of its regulatory activities.

I consent to the collection, use and disclosure of my personal information and my child's as set out above.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____