Office Policy

TIM M. VERWEST, DMD & ASSOCIATES
P: 239.482.2722 | **F:** 239.482.7877
8016 Summerlin Lakes Drive | Ft. Myers, FL 33907
1035 Piper Blvd Suite 101 | Naples, FL 34110

1. Our office submits all Medicaid ID numbers through the State's eligibility program at the beginning of each month. Any appointments for ineligible ID numbers **will be cancelled automatically**, without notice to you.

2. Parents of children having cleanings can keep the appointments IF we receive at 24 hours notice of alternative Insurance information or intentions to be self-pay.

3. Parents of children having restorative work must call the office to **RE-SCHEDULE** the cancelled appointment to our next available opening.

I agree to give Dr. Verwest a 24 hour notice of any cancellation I may make.

I understand that if my child/children cancel or reschedule three times for a scheduled appointment for any reason. They will no longer be seen in this office.

I further understand that I must keep Dr Verwest's office updated with a current, valid phone number for appointment confirmation. All wrong numbers and numbers that are **Not In Service** will **not be** considered confirmed appointments and **may be cancelled** without notice to you.

We apologize, in advance, for any inconvenience this may cause you.

DR. VERWEST & STAFF

WAIVER: I agree to pay for any services that are not covered by Medicaid, or services that are over the cap for frequency limitations. I am responsible to let Dr. Verwest and his staff know of any treatment my children have received from ANOTHER PROVIDER.

Print Name: _____ Signed: _____

Please list ALL children you are responsible for:

_____ _____

_____ _____

_____ _____

Financial Policy

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Thank you for choosing us as your child's dental office. We are committed to providing your child with optimum dental care. Please understand that payment of your bill is considered part of your child's dental treatment. The following is a statement of our financial policy which we require you to read and sign prior to any dental treatment.

Payment is expected at time of service:
We accept cash, checks and major credit cards (Visa, Mastercard, American Express & Discover credit cards and Visa/Mastercard backed Debit cards.

Minor patients of divorced parents:
A divorce decree is a legal agreement binding only upon the two parties who made the agreement. Regardless of whom the judge deemed financially responsible for dental bills. **THE PARENT WHO BRINGS THE CHILD TO THE OFFICE FOR DENTAL TREATMENT IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.** The parents can settle the financial responsibilities between themselves. Do not ask us to do this for you.

DENTAL INSURANCE:

We will accept your insurance as **partial payment** for your child's dental treatment. We are not contracted with all Dental Plans, therefore there maybe a difference between our fees and those of the insurance company-you are responsible to pay this difference, along with all other co-insurance amounts and services.

We do not file claims to HMO or DMO plans that we are not contracted with. We do not file insurance claims for Emergency visits. Consults or Office Visits not associated with periodic cleanings or treatment. The parent accompanying the child will be responsible to pay at the time of service and we will provide you with a form to submit to your insurance for reimbursement.
To determine exactly what benefits you qualify for under your plan, it may be necessary to submit to your insurance a "predetermination of benefits". If you wish to begin treatment before your insurance company declines your exact benefits you will be required to pay 50% of the fee for your child's dental treatment. Once we receive notice of reimbursement from the insurance company we will adjust your account accordingly.

I understand that it is a courtesy of Dr. Verwest's to file my insurance and I agree to pay any and all balances not paid by my insurance after 60 days from time of service. It is my responsibility to get reimbursement from my insurance company.

I understand that if any balance on my account goes unpaid for 90 days, my account may be turned over for future collection action and a 30% fee will be added to my account.

Thank you for understanding our financial policy.

I have read the above financial policy. I understand and agree to this financial policy.

Signed: _____ Date: _____

Privacy Policy

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Child(ren) Name (s)_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I have received a copy of the Notice of Privacy Practices of Pediatric Dentistry of Florida. I hearby authorize, as indicated by my signature below, Pediatric Dentistry of Florida to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent Form.

_____ _____

Print Parent/Guardian Name **Address**

_____ _____

Signature Parent/Guardian **Date**

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number _____
- ☐ You may contact me on my mobile telephone number _____
- ☐ You may contact me at my work telephone number _____
- ☐ You may send me unencrypted email/text message at: _____
- ☐ Other _____

Please list all authorized persons with whom we may discuss you Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____/Relationship_____ Date Added/Removed:_____
2. _____/Relationship_____ Date Added/Removed:_____
3. _____/Relationship_____ Date Added/Removed:_____
4. _____/Relationship_____ Date Added/Removed:_____

For office use ONLY

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please specify): _____

Staff Person Initials _____

PEDIATRIC DENTISTRY of Florida

General Information

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Parent or Guardian _____ Parent or Guardian _____
Relationship _____ Relationship _____
Home Address _____
City _____ State _____Zip Code _____
Contact # _____ **Email Address** _____

Father's Occupation _____ Social Security # _____
Employed by _____ Address _____ Phone _____
Mother's Occupation _____ Social Security # _____
Employed by _____Address_____ Phone _____

How did you hear about us or whom may we thank for referring you?_____

CHILD'S INFORMATION

Name_____ Nickname _____
Birthdate _____ Age _____ Gender : ☐ M ☐ F
Attends what school?_____Grade: _____
Child's Physician or Pediatrician and address_____
PARENTS' adult dentist _____

MEDICAL HISTORY *Has your child experienced any of the following?*

	YES	NO		YES	NO
Allergies	____	____	Hepatitis	____	____
Anemia	____	____	Endocrine Disease	____	____
Asthma	____	____	Kidney Disease	____	____
Bleeding Disorder	____	____	Liver Disease	____	____
Bronchitis	____	____	Lung Problems	____	____
Behav/Learning Problem	____	____	Mental Disorder	____	____
Diabetes	____	____	Nervous Disorder	____	____
Epilepsy	____	____	Rheumatic Fever	____	____
Fainting	____	____	Seizures	____	____
Hearing Disorder	____	____	Speech Disorder	____	____
Heart Disease	____	____	Tonsils/Adenoids	____	____
Frequent Headaches	____	____	Birth Defects	____	____
Cancer/Tumors	____	____	Blood Transfusions	____	____
Frequent Infections	____	____			

Do you need communication assistance (Braille or sign language)? ☐ Yes ☐ No

Patients Primary Language? _____

Has your child been hospitalized, and if so, when? _____

Has your child ever had anesthesia? _____

Has your child ever suffered any significant injuries, and if so, when?

_____

When was your child's last physical examination?

_____

Is your child taking any medication at this time? List if any:

_____

Has your child had any unfavorable reactions or allergies to any medication such as penicillin, aspirin, or novacaine? List if any: _____

DENTAL HISTORY & TREATMENT

Does or has your child suffered from any TMJ/TMD problems?_____

When was your child take off the bottle?_____

1. What are your concerns about your child's dental health or information that would be valuable to us considering treatment.

_____

_____

2. In general, most children are cooperative and have good behavior during treatment, would you predict your child's behavior to be (circle all that would apply): **Don't know** **Cooperative** **Fearful** **Stubborn** **Apprehensive** **Defiant**

3. When treatment requires local anesthesia (numbness) we often use nitrous oxide (laughing gas) in addition to anesthesia to relax the patient and make treatment easier.

I certify that I have read and understand the above. I acknowledge that the questions above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I have received written information regarding advanced directives. (If applicable)

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of treatment.

I do hereby authorize and request the performance of dental services for my child and the use of whatever procedures Dr. Verwest and staff may deem necessary during treatment. I understand that Dr. Verwest and his assistants will use preventive, restorative, oral surgery, and patient management techniques that are reasonably necessary, and advisable. I also authorize the administration of anesthetics, or analgesics which may be deemed advisable by Dr. Verwest. I understand that though he will do his best to provide quality dental therapy, no guarantee is given or implied by Dr. Verwest or his staff for services rendered. I understand that the treatment plan, and fees could change depending upon the extent of dental disease and the time elapsed since the initial examination. I also authorize release of this information to the patient's medical doctor of record.

PLANNED TREATMENT

Most insurance companies pay only a portion of the fee for dental treatment. The amount they pay is based upon your insurance policy. We will be glad to work with your insurance company, but it is important to remember that its your responsibility to make up the difference in cost that your insurance company does not pick up.

I understand that if any balance on my account goes unpaid for 90 days, my account may be turned over for future collection action and a 30% fee will be added to my account.

_____

Parent/Guardian