Sprout
Kids Dentistry

Appointment Policy

Children respond best to dental treatment when they are not tired. We encourage morning appointments, especially for 1st visits, pre-school or nervous children, or children with a lot of dental work to complete. For many children, just a simple filling at the end of a long day, when tired, can seem like a major ordeal. Keep in mind that a dental appointment is an excused absence from school. When we schedule an appointment for your child that time is reserved exclusively for your child. For this reason, it is very important that your family arrives on time for your scheduled visit. If you are more than 15 minutes late, we may decide it is necessary to reschedule your child's visit.

Emergencies: Emergency visits are by appointment only AND for patients of record only. We will always attempt to see your child as quickly as possible.

Cancellations, Rescheduling, or Broken Appointments: If you are unable to keep a scheduled appointment, 48-hours notice is required. We understand that unforeseen emergencies do occur, however, we reserve the right to charge your account a $20.00 fee per child after a series of two (2) missed or broken appointments outside of the 48-hour guideline. A charge will be applied to your account before another visit can be scheduled. If your child has missed or broken two (2) consecutive appointments for a dental cleaning in a calendar year, OR your child has missed or broken two (2) or more appointments for dental work in a calendar year, we reserve the right to request that your child establishes care at another dental office that can better accommodate your schedule.

Effective Date: Once you have signed this policy, you agree to all the terms and conditions contained herein and this agreement will be enforced and in full effect.

Initial: _____

I have read and understand the policies and conditions of Sprout Kids Dentistry as it relates to my child's dental care. I authorize Sprout Kids Dentistry to release information about my child to third party payers and/or other health practitioners that includes a diagnosis and treatment records. I authorize and request that my insurance company pays the dentist directly for covered benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual billed amount for services rendered to my dependent and in such instances, I agree to be responsible for the full or partial balance of payment due at the time of service. I affirm that my signature represents my agreement to all the terms and conditions outlined above.

Parent or Legal Guardian Print Name:

_____

Parent or Legal Guardian Signature:

_____ Date: _____