Jiyoung E. Lee, DMD
Gresham Pediatric Dentistry

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Welcome to Our Practice!

Thank you for selecting our dental healthcare team at Gresham Pediatric Dentistry! We will constantly strive to provide you, and your child with the best possible dental care.

Patient Information

Today's Date_____
Patient's Name(s) _____ Name Preference(s) _____
Address _____City _____ State___ Zip _____
Contact Phone _____
Email _____
Date of Birth(s) _____

Names of guardian(s) or parent (s) _____
Person to contact for emergency _____ Relationship_____ Phone _____
Whom may we thank for referring you to our office? _____

Responsible Party Information (If different than above.)

Name _____ Relationship to Patient _____
Address _____City _____ State ___ Zip _____
Home Phone _____ Date of Birth _____

Dental Insurance Information

Dental Insurance Co. _____ Effective Date _____
Address _____ City _____ State ___ Zip _____
Name of Policy Holder _____Date of Birth _____
Member # (or SSN #) _____ Group # _____

Secondary Insurance Co. _____ Effective Date _____
Address _____ City _____ State ___ Zip _____
Name of Policy Holder _____ Date of Birth _____
Member # (or SSN #) _____ Group # _____

I acknowledge that the above information is accurate. I hereby authorize payment of benefits directly to the provider, and the release of all necessary information to the insurance carrier. I understand that by signing below I am responsible for charges for all consented treatment, and that fees not covered by insurance are due on the day of service.

Signature _____ Date _____

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FINANCIAL AGREEMENT AND OFFICE POLICY

This is an outline of our financial agreement and office policy. During the initial appointment, all necessary records and information for a 'New Patient' appointment will be obtained, including x-rays, exam, and oral hygiene instructions. At that time we will discuss our findings, proposed treatment, discuss fees and make financial arrangements. Financial arrangements are individualized, vary for each account, and are based on the information you provide at the initial visit.

1. Payment is due at the time of service.

2. If your child will be sedated at our office, a sedation fee will incur at the time of administration regardless of sedation outcome. Each child responds differently to the medication (sleeping, crying, getting angry), and this cost is for the medication, staffing, as well as equipment.

3. While we try our best to give you the most accurate treatment plan, treatment may change when the dentist starts decay removal. This can result in a change of the proposed treatment cost. The staff will inform you of any changes when they occur.

4. Dental insurance patients:
    1. If you have dental insurance that requires our collection of a deductible and/or copayment, that amount is due at the time of service.
    2. Any change of insurance should be noted in your account at the beginning of every appointment and is your responsibility to inform our staff of any changes.
    3. If your child has had dental treatment completed in the past 12 months at any other office, your insurance may not cover our charges. Our office will assist your family in obtaining information regarding the insurance plan, but be advised: you are still financially responsible for your child's appointment.

5. **We reserve the right to not reschedule appointments cancelled without a 24 working hour notice. Sedation appointments cancelled or failed without a 48 working hour notice may result in office dismissal. Our office provides an answering service for messages. Please leave us a message or email us.**

6. **We reserve the right to cancel upcoming appointments due to missed appointments within the family, financial reasons, or any reason deemed necessary.**

7. If other means to collect a balance are necessary, we will be as aggressive as is indicated to collect the account, i.e., small claims court judgements, garnishments.

8. We reserve the right to charge for duplicate records or any rebilling.

I HAVE READ AND REVIEWED THE OFFICE POLICIES AND ASKED ALL NECESSARY QUESTIONS. I ACCEPT THESE ARRANGEMENTS.

Signature _____ Date _____

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Understanding Dental Insurance

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception: ***dental insurance is not designed to pay for all of your dental care***. Most contracts have yearly limits, treatment limitations and/or various degrees of "co-payments".

All levels of payment by insurance companies, including allowed fees, usual, customary, and reasonable (UCR) are governed by the premiums paid. They have nothing to do with the actual fee for the services rendered. Our fees are based upon a combination of our costs, our time, and our consistent dedication to providing our patients with the highest quality of dental care. Thus, there is often a discrepancy between the amount covered under your policy's UCR schedule, and the actual cost of the procedure. The discrepancy is the patient's responsibility.

The treatment recommended by our practice is never based on what your insurance company will pay, as your oral health care and accompanying treatment should not be governed by your insurance company contract.

Thus, it should be understood that ***the dental insurance contract is between the insurance company and the patient.*** If you are unclear as to whether a particular procedure is covered by your carrier, please submit a pre-estimate for treatment before scheduling.

We hope this information has been helpful. Please take the time to review your insurance policy's nuances thoroughly so that we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing and insurance.

SIGNATURE: _____

DATE: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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