



**General consent**

I request and authorize Little Pearls Dentistry for Children, Dr. Michael Gazori, his associates, and staff (at his direction) to perform examination, cleaning, radiographs (x-rays), photographs, and fluoride for my child as necessary. I agree that radiographs and/or photographs may be used for educational purposes and understand that no information identifying my child will be present on such images if used. I also understand that any treatment needs will be explained to me prior to treatment and will require additional consent.

I state that I am the child's legal guardian and that I have read and agree to follow all office policies stated on the website and available within the office. This consent will remain in effect unless canceled in writing.

I agree to notify this office of any change in my child's health, including any allergies or current medications/supplements.

I authorize Little Pearls Dentistry for Children to release any information necessary for the processing of dental insurance claims and authorize direct payment to Little Pearls Dentistry for Children of the insurance benefits otherwise payable to me.

Child(ren)s' names \_\_\_\_\_

Name of parent/guardian \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Financial consent**

I acknowledge that I have read and agree with the office financial policy. ***I understand that any estimate of my insurance benefits is solely an estimate and not a guarantee of payment.*** I understand this office bills my insurance as a courtesy and is not required to file my claims either legally or contractually. I am ultimately responsible for knowing the benefits and limitations of my plan. I understand this office only places composite (tooth-colored) fillings and I may have a higher copay if my insurance only covers amalgam (silver) fillings for back teeth. I also understand other charges such as (but not limited to) nitrous oxide (laughing gas) and fluoride may not be covered by insurance and will be my financial responsibility. Initial: \_\_\_\_\_

I certify that I have given the correct insurance information to the office and will notify the office of any changes in insurance company or coverage. I also understand that fees and treatment needs are subject to change and previous estimates are not to be considered a guarantee. Initial: \_\_\_\_\_

I acknowledge that payment in full is expected in cases of no insurance unless extended financing has been obtained. Initial: \_\_\_\_\_

I agree that balances over 45 days after the appointment date be applied to my credit card and that I will be responsible for obtaining insurance reimbursement for any outstanding claims. I understand that I will be responsible for legal or collections fees if my account becomes overdue. I understand 48 hours notice is required to cancel or reschedule an appointment otherwise my account will be charged \$35 per child and numerous missed appointments may result in termination of the doctor-patient relationship. This consent will remain in effect unless canceled in writing. Initial: \_\_\_\_\_

Child(ren)s' names \_\_\_\_\_

Name of parent/guardian \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Credit card: MC VISA AMEX DISC # \_\_\_\_\_ Exp \_\_\_\_\_