AL Pelphrey, DMD, FAAPD
Pediatric Dentistry

PATIENT PARTNERSHIP AGREEMENT

Dear Parent(s);

We are pleased that you chose our practice to provide your child's dental care. We are delighted to accept your child as a patient of this practice. Our commitment is to provide the highest level of Pediatric Dental care available to your child in the safest environment possible in a friendly and courteous manner. The Doctor/Patient relationship is a mutually beneficial relationship and as such requires commitment by both parties. In order for us to provide your child with appropriate dental care, we need your commitment to our office policies. Please read and initial each policy:

1. If you have private dental insurance, please provide us with a copy of the insurance card and a list of benefits provided to you. Please keep in mind that dental insurance is a contract between you and the insurance company. As a courtesy, we will file insurance claims for you. We cannot guarantee coverage for any treatment. All co-payments, deductibles and fees for non-covered services are to be paid at the time of service. ________

2. We reserve specific appointment times in our schedule for your child's treatment. You will be provided with an appointment card for each visit to our office. It is your responsibility to remember your appointment time and to arrive on time. In order for us to properly utilize the time we have scheduled for your child and out of respect for those patients who arrive on time, late arrivals could result in your child's appointment being rescheduled. In the event an emergency prevents you from arriving on time, we ask that you notify our office as soon as possible so that we may adjust our schedule to accommodate you if possible.______

3. Broken appointments are not acceptable. Your appointment with the doctor is a time reserved for your child only. In the event you require changing an appointment, we require a 24 hour notice. Failure to provide us with a 24 hour notice or failure to show for a scheduled appointment will be considered a broken appointment. **Because of the hardship it places on our practice, repeated broken appointments will result in termination of our doctor/patient relationship.**______

4. Preventive dental care at home (brushing, flossing and proper diet) is a vital component of your child's successful dental treatment. We ask that you make preventive home care a priority. For infection control purposes, we also ask that you always have your child **brush before each dental visit**.______

5. After each examination, you will be provided with a treatment plan consisting of necessary dental treatment for your child and the **estimated** cost. These treatment recommendations are made according to acceptable standards of care and what I feel is in your child's best interest. You are encouraged to ask questions and be involved in decision making when it comes to your child's treatment. Once we have agreed on a plan of treatment, we ask that you have the recommended treatment performed in a timely fashion to prevent more serious problems from occurring. **Failure to have necessary dental care provided in a timely fashion or failure to follow routine preventive recommendations can result in your child experiencing more serious and more complicated dental problems.** ______

6. We invite parents to accompany their children during New Patient and Recall Appointments. During your child's dental appointment for treatment (fillings, extractions, etc) it is necessary for Dr.Pelphrey to have your child's full attention. Both he and your child need to be free from any distractions. Therefore, Dr. Pelphrey asks that the parents remain in the waiting room during these appointments. In the event Dr.Pelphrey feels the parents are needed during treatment, you will be invited to the treatment room. _________

7. In order to keep your child's dental record current and accurate, we ask that you notify our front desk staff of any changes in address, phone numbers, insurance information and medical status as soon as possible. _________

8. By accepting treatment recommendations, you are entering into a contractual financial agreement to pay for services provided to your child. We accept a variety of payment methods such as cash, insurance, personal check, money order and credit/debit card. **We expect fees to be paid at the time of service**. In the event your account becomes delinquent due to unpaid balances we reserve the right to seek remedy by any means available to us. In the event this becomes necessary, you accept financial responsibility for any fees/charges encountered when attempting to collect on a delinquent account._______

We look forward to a long lasting, caring, professional relationship with you and your child. . If you have any questions in regards to any of the above policies please make us aware of your concerns or questions. By signing below, you accept our office policies..

____   ________________________
parent/guardian   date

July 2004