



Crystal Walker, DDS, PA

7075 W. 37th St. North, Suite B, Wichita, KS 67205
(316) 613-2077



Crystal Walker, DDS

www.jumpreachgrowsmile.com

Mariah Frazier, DDS

Consent Form

I hereby authorize, for the patient named below, examination and treatment by members of the team of Crystal Walker, DDS, PA and any assistants or designees deemed necessary by Dr. Walker and/or Dr. Frazier. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations in this office.

RELEASE OF INFORMATION

I authorize the release of information concerning my child's office visit to and/or from the primary care physician, family physician, referring physician or dentist.

PHOTOGRAPHS

I authorize the taking of a digital photograph of my child for his/her dental file.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I hereby authorize payment of third-party benefits, otherwise payable to me directly to Crystal Walker, DDS, PA not to exceed the doctor's regular charges. I understand that I am financially responsible to the hospital and/or doctor for the above named patient and I agree to pay Crystal Walker, DDS, PA all amounts incurred by the below named patient not covered by a third party payer, due by me at the time of service.

APPOINTMENT AND FINANCIAL POLICY

I have fully read and understand the reverse side containing information about scheduling my child's appointments as well as my financial responsibilities regarding the charges occurred during my child's dental visit.

NO SUGAR BUG CLUB CONSENT

I authorize my child's name to be posted in the office and/or on the office website if they become a member of the No Sugar Bug Club which will allow them to participate in the prize drawing for their outstanding oral hygiene habits.

Patient's Name

Date of Birth

Printed Name of Responsible Party

Relationship

() _____ - _____
Phone Number

Signature of Responsible Party

Today's Date

INTERPRETER CONSENT

I, _____, read the above statement to _____ he/she understands and approves consent as stated above.

Interpreter's Signature

Responsible Party Signature

Today's Date



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There are many children in the community that we wish to help. Therefore, if you are unable to keep your reserved appointment, we ask that you contact us with a 24 hour notice. Otherwise, as of July 1, 2011 your account will be charged a \$50.00 fee per appointment.

Appointment Policy

Patients that arrive more than 10 minutes late for their reserved appointment may be asked to reschedule.

- We have reserved a specific time to spend with your child. It is important to be on time for your visit so we can provide the best dental care possible to your child during their appointment.
- Our office requires a 24 hour cancellation notice for any scheduled appointment. Advance notice of a cancellation allows us to provide other patients with their dental care needs.
- If any family member fails to show for 1 reserved appointment or cancels without 24 hour notice, that family will be sent a letter stating that there will be one last attempt to reserve an appointment. If the second scheduled appointment is not kept ALL family members will become inactive and must seek treatment elsewhere.
- Any **NEW PATIENT** that has a reserved appointment in our office and fails to show or cancels without proper 24 hour notice for the initial appointment will NOT be rescheduled and must seek treatment elsewhere.

Financial Policy

Our office requires payment in full at the time of service for charges not covered by your chosen dental insurance plan.

If you are a member of a Dental Insurance Plan and have chosen us as a provider of your child's care, it is your responsibility to:

- *Find out if we are a participating provider for your specific insurance plan.
- *Provide us with information relative to your claim, including insurance card, ID number/group number, employer, name of insured, date of birth, address and Social Security number. This information is requested on the Patient information form, which we ask that you complete during your initial or subsequent visit.
- *Pay for services not covered by your insurance carrier at the time of service.

We are in-network providers for:

Blue Cross Blue Shield of Kansas, Delta Dental and Kansas Medicaid.

As a courtesy to you our office will file your dental insurance claim. You may be asked to pay up to 25% of the total dental charges for your visit, prior to your insurance being filed.

If we are NOT a participating provider with your dental insurance you may be asked to pay up to 35% of the total dental charges at your dental visit.

- To assist you with your payment, our office accepts Cash, Check Visa ,MasterCard and Care Credit. Care Credit is a convenient, low minimum no interest monthly payment plan designed to pay for healthcare services not covered by insurance. Visit www.carecredit.com for more information or call 1-800-365-8295.
- Personal checks are excepted with proper identification (driver's license or photo ID). **A \$30.00 overdraft charge will be posted to your account for each insufficient check.**
- If you can not provide proof of insurance you will be expected to pay in full at the time of service.

If your account becomes 90 days past due, your account may be handed over to our collection agency. You will be responsible for all costs of the collection process, as well as your portion of the dental services.