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.

______________________________ 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

Revised January 2, 2010

Crystal Walker, DDS, PA

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

Crystal Walker, DDS
Mariah Frazier, DDS

Appointment Cancellation Policy

If you arrive at our office more than 10 minutes after your scheduled appointment time you may be asked to reschedule that appointment.

- 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.

Fail To Show for Appointment

- If any family member fails to show for 1 scheduled appointment or cancels without 24 hour notice, that family will be sent a letter stating that there will be one last attempt to reschedule 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 scheduled appointment in our office that fails to show or cancels without proper 24 hour notice for the initial appointment will NOT be rescheduled.

Patient Financial Policy

Our Policy requires payment in full at the time of service for charges not covered by insurance.

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 contracting providers for: Blue Cross Blue Shield of Kansas, Cigna, Delta Dental and Medicaid.
As a courtesy to you our office will file your dental insurance claim

- 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 collection agency. You will be responsible for all costs of the collection process, as well as your portion of the dental services.

Revised January 2 , 2010