Amanda N. Siu, D.D.S.
Board Certified Pediatric Dentist

OFFICE POLICIES

Welcome to our dental practice! We are delighted that you have chosen our office to care for your child's dental needs. It is the intention of the following office policies to assist in making your child's treatment as pleasant and efficient as possible.

I. Insurance

1. As a courtesy to our patients, we will bill your insurance company for you but will require your portion and/or deductible at the time of each visit.
2. The office will bill you directly for any portion owing that insurance has not covered. You are ultimately responsible for your account.
3. Should your insurance company reimburse you directly, payment will be expected in full at the time of each visit.

II. Payments and Charges

1. Your time is valuable and Dr. Siu makes every effort to see patients on time for their appointments. Please be considerate of our time by giving us a 24 hour notice of an appointment cancellation. Failure to do so will result in a $50 charge. If you are more than 15 minutes late for an appointment, it is up to the discretion of Dr. Siu to determine whether or not there is time for your child to be seen. Rescheduling the appointment may be necessary.

III. Overdue Accounts

1. Payment arrangements can be made in advance with the office manager in order to keep your account current.
2. Accounts over 90 days will be sent to collections if no effort is made to settle your account.

V. Changes to Patient Information

1. It is my responsibility to inform the dental office of any changes to my child's:
    a. Insurance
    b. Medical status

VI. Authorizations

1. I hereby authorize this office to take necessary photographs, x-rays, and other diagnostic aids to properly diagnose and evaluate my child's dental needs.
2. My signature below authorizes and serves as assignment of benefits from my insurance company and that payment is made to this office directly for services administered to my child.
3. I further authorize this office to furnish and/or release any information necessary to insurance carriers concerning my child's dental treatment in order to process my insurance claim.
4. I have read and understand the office policies and agree to adhere to them.

Patient(s) Name (if a minor): _____

Patient / Guardian Printed Name: _____

Patient / Guardian Signature: _____

Date: _____