Dr. Katharine J. Pins
Dr. So Young Park

100 S. 4th Avenue, Unit 2
Eldridge, IA 52748
563-285-5600

www.ClassicConceptsDental.com

Important Information

DENTAL INSURANCE

Classic Concepts Family Dentistry, P.C. is in-network with most dental insurance carriers and will file your dental claim with your insurance carrier on your behalf. The terms of your dental insurance policy and coverage under that policy are a matter between you and your carrier. We are happy to estimate your patient portion for services but please remember that this will be only an estimate of your patient portion and the final determination of your personal obligation will be determined by your carrier. We ask for payment of your estimated portion of your bill at the time of service and will forward to you a statement of any remaining balance due once a determination of benefits is received by us from your insurance carrier.

PAYMENT POLICY

Your estimated patient portion, as indicated above, is due at the time of service unless other arrangements have been made in advance. Classic Concepts Family Dentistry, P.C. accepts cash, personal checks, Debit Cards, Visa, Master Card, Discover Card, American Express and Care Credit. A $25.00 non-sufficient fund charge will apply if a check submitted in payment is returned by your bank or credit union.

Acknowledgement: I understand that all responsibility for payment of services provided by Classic Concepts Family Dentistry P.C. for myself or dependent(s) is mine alone and that payment is due at the time of service unless special arrangements have been made in advance. In the event of non-payment on my account, I may be subject to collection action and additional collection charges, including but not limited to attorney fees and court costs. I hereby submit to the jurisdiction of the Scott County, Iowa, District Court relating to the same. I further understand accounts must be in good standing to make future appointments for routine dental care.

x _____
Please Initial

MINOR PATIENTS

A parent or legal guardian must accompany the minor when dental services are being provided unless arrangements are made in advance, including payment of estimated patient portion.

CANCELLED APPOINTMENTS

Cancelled Appointments. Our office requires a minimum 24 hour business day notice to cancel or reschedule an appointment. This notice allows us time to schedule another patient desiring treatment. Classic Concepts Family Dentistry, P.C. reserves the right to charge a $25.00 cancellation fee for abuse of this notice requirement, i.e., your failure to properly provide notice of cancellation or reschedule, which fee is not chargeable to your dental insurance carrier and which will be a patient responsibility. This fee of $25.00 must be paid prior to scheduling further routine dental care.

Please see other side

APPOINTMENT REMINDERS

Classic Concepts Family Dentistry, P.C. will make every effort to contact you by post card, electronic means and/or telephone to remind you of your dental appointment, however, our failure to do so will not avoid your responsibility for keeping your dental appointment. We would appreciate your returning a call, text or e-mail reminding you of your appointment in a timely matter so that we may confirm your scheduled appointment.

Mobile Phone Number: _____

E-Mail Address: _____

AUTHORIZATION FOR DENTAL TREATMENT

I hereby authorize Classic Concepts Family Dentistry, P.C. to provide dental services and to prescribe, dispense, and/or administer any drugs, medicaments, antibiotics and local anesthetics deemed appropriate or necessary as a matter of professional judgment, by Dr. Pins and staff. I acknowledge that I fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic or local anesthetic. I understand there are inherent risks involved in any dental treatment. The most common risks can include but are not limited to:

Bleeding, swelling, bruising, TMJ discomfort/inflammation, infection, aspiration,
paresthesia, nerve disturbance or damage either temporary or permanent,
adverse drug reaction, allergic reaction, anaphylaxis, or cardiac complications.

I acknowledge I have an obligation to follow any instructions given by office staff including the taking of any medication prescribed as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Date: _____

Patient Name (printed): _____

Legal Guardian or Patient Signature: _____

Witness: _____