Dr. Julie M. Russo
Diplomate of the
American Board of Pediatric Dentistry

Office Policies

We appreciate your allowing us to provide dental care for your child. We value our relationship with you and believe that the best relationships are based on understanding and good communication; we offer these clarifications of our office policies.

Parent Information

A parent is welcome to accompany their child on their first visit to view our facilities and to personally meet the doctor and staff. For the safety and privacy of all patients, other children and family members who are not being treated must remain in the reception room with a supervising adult. Everyone will make a great effort to ensure that your child feels comfortable in these new surroundings. Since this first visit will establish their initial attitudes towards dentistry, it is very important to make this appointment a positive encounter. If you choose to accompany your child at this initial visit we ask that you please remain in the designated 'parents area' and play the role of a silent and supportive observer. We know that the trust we have established with the parents and child at this initial visit will make for an easy transition when the child is unaccompanied for subsequent visits. This allows the child to establish an uninterrupted relationship with the doctor and staff and enables them to gain confidence during dental treatment. If, at any time during treatment, we feel the need for parental involvement, we will invite the parent back.

Appointment Policy

If your child is under the age of 6 we request that you schedule a morning appointment. Younger children do better when they are well rested. Your scheduled appointment time has been reserved specifically for your child. We request 24 business hours notice if you need to cancel an appointment. We are aware that unforeseen events sometimes require missing an appointment. However, if you do miss an appointment without notifying us 24 business hours in advance, a cancellation fee will be applied to your account. The cancellation fee will vary depending on the length of time reserved for you and your child.

Infection Control

We utilize the most effective infection control measures and fully comply with all OSHA and CDC standards for sterilization. We maximize our use of disposable materials and autoclave all of our hand instruments.

We welcome any questions!

I have read and understand the Office Policies and agree to abide by its contents:

Parent/Guardian____ Date:________________

1804 Oakley Seaver Drive Suite G Clermont, Florida 34711
Phone: 352-241-6333 Fax: 352-241-0706
www.ClermontPediatricDentistry.com

1804 Oakley Seaver Drive
Suite G
Clermont, Florida 34711
www.ClermontPediatricDentistry.com
Tel: 352-241-6333   Fax: 352-241-0706

Patient ____________________

Name child would like to be called ____________ Birthdate ________ Age ____ Sex ____

Address ____________________ Apt/Suite# ________

City ____________ State ______ Zip ______ Home Phone ____________

School / Grade ____________________

Child's Interests (favorite toy, movie, etc) ____________________

Names and ages of other children in family ____________________

Mother ____________________ Employer ____________

SS# ____________ Birthdate ____________ Work Phone ____________

Email Address ____________________ Cell Phone ____________

Father ____________________ Employer ____________

SS# ____________ Birthdate ____________ Work Phone ____________

Email Address ____________________ Cell Phone ____________

Who has legal custody of the patient? ____________________

How did you hear about our office? ____________________

What is the reason for your child's dental visit? ____________________

Additional Comments ____________________

____

____

____

____

Primary Policy Holder Name ____________________

SS# ____________ DOB ____________

Insurance Carrier Name ____________________

Address ____________________

____

Group/Policy # ____________________

Subscriber ID# ____________________

Employer of Insured Name ____________________

Address ____________________

____

____

I authorize my insurance to pay directly to my dentist if my insurance plan is **Delta Premier, Delta PPO**, *or* **Metlife PDP**. *If I am covered by any other plan, I will pay in full when services are rendered. I understand that all insurance policies are different and I am responsible for knowing my plan provisions. I understand I will be responsible for all co-payment, deductible, and rejected charges.*

Signature: ____________________ Date: ____________

☐ Yes ☐ No Is your child in good health? Name of child's physician ______________________________

Date of last physical exam ______________________________

☐ Yes ☐ No Has your child ever had a health problem? ______________________________

☐ Yes ☐ No Are your child's immunizations up-to-date? ______________________________

☐ Yes ☐ No Has your child had any operations? ______________________________

☐ Yes ☐ No Is your child currently taking any medications? Please list medication(s), dose(s), and reason(s) ______________________________

____

☐ Yes ☐ No Were there any problems at birth? ______________________________

☐ Yes ☐ No Is your child allergic to anything? ______________________________

Please check if your child has been diagnosed, treated or is being treated for any of the following:

☐ AIDS/HIV	☐ Diabetes	☐ Hepatitis	☐ Tuberculosis	☐ Mental delays
☐ Anemia	☐ Epilepsy / Seizures	☐ Kidney Disease	☐ Congenital birth defects	☐ Physical delays
☐ Asthma	☐ Excessive Bleeding	☐ Liver Disease	☐ Cerebral palsy	☐ Social delays
☐ Blood Disorder Transfusion	☐ Frequent Headaches	☐ Rheumatic fever	☐ Cleft lip / palate	☐ Speech / hearing problems
☐ Cancer / Tumors	☐ Heart Condition / Murmur	☐ Stomach / GI disease	☐ Frequent infections	☐ Autism
☐ ADD/ADHD	☐ Psychiatric Care	☐ Other		

Please elaborate on any items checked ______________________________

____

Do you consider your child to be : ☐ advanced in the learning process ☐ progressing normally ☐ slow in the learning process

Was your child: ☐ breast fed ☐ bottle fed At what age was it stopped? ______________________________

☐ Yes ☐ No Has your child ever been to the dentist? Date of last dental visit? ______________________________

Name of dentist ______________________________

☐ Yes ☐ No Has your child ever had dental x-rays? Date: ______________________________

☐ Yes ☐ No Do you think your child will react well to dental treatment? If not, explain: ______________________________

☐ Yes ☐ No Has your child ever sucked a finger, thumb or pacifier? Ages when? ______________________________

☐ Yes ☐ No Does your child brush his/her own teeth? How often? ______________________________

☐ Yes ☐ No Do you or your child use dental floss? How often? ______________________________

☐ Yes ☐ No Does your child have snacks between meals? ______________________________

☐ Yes ☐ No Have your child's teeth ever been injured? When? Which teeth? ______________________________

Treatment? ______________________________

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds? ______________________________

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Toothache	☐ Sensitive teeth
☐ Surgical Mouth Treatment	☐ Gum Infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: ______________________________

____

____

☐ Yes ☐ No Is your home water supply fluoridated?

☐ Yes ☐ No Does your child use a fluoride toothpaste?

☐ Yes ☐ No Does your child use a fluoride supplement? *Dose:* ☐ *0.25mg* ☐ *0.50mg* ☐ *1.00mg*

☐ Yes ☐ No Do you give your child any other forms of fluoride? What? Amount? ______________________________

Please understand that financial arrangements are made directly with you. For your convenience, the following outlines our financial policies:

1. **Payment is due in full** for each appointment as services are rendered and is to be paid by the person accompanying the child. We accept cash, personal checks (with valid photo ID), Mastercard, Visa, American Express, Discover and Care Credit. A charge of $30.00 will be assessed on checks returned for any reason. You will be responsible for payment of all costs and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.

2. **Dental Insurance:** It is our policy to not accept assignment of benefits for dental insurance other than **Delta Dental PPO**, **Delta Dental Premier**, and **Metlife PDP.** For all other insurances we will be happy to submit a claim to your insurance electronically, however payment is due in full at time of service. The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. Any reimbursements by your insurance company other than those we directly participate with should be made directly to you according to the terms of your contract with them.

4. **Pre-treatment Authorization:** Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefit is determined.

5. **Fillings:** Our dental material of choice is a white (composite resin) filling. Please be aware that your insurance company may not pay for a resin filling at the same level as a silver (amalgam) filling. The co-payment is your responsibility. In some cases, the dentist may recommend placing a silver crown instead of a resin filling.

6. **Nitrous Oxide / Analgesia:** Our office uses Nitrous Oxide Analgesia (Laughing Gas) for the comfort of our young patients. This fee is is not always covered by dental insurance. We thank you for your payment on the date of service.

7. **Appliances:** The entire cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory bills when appliances are ordered, not when they are completed.

8. **Emergency Treatment:** All emergency treatment must be paid in full at the time the service is rendered.

Please remember, even if you have insurance coverage, **you are responsible for payment of your account.** *Understand that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated.You are helping us keep our overhead expenses, in the form of direct and labor costs, down. In addition, you are helping keep your fees as low as possible. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency. You agree to pay any and all attorney fees associated with the collection of monies due.* ***I have read and understand my obligation.***

Signature: ____ Date:______________________

I request and authorize Dr. Russo and her staff to examine and provide my child with comprehensive dental treatment including cleanings, fillings, crowns, extractions, and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Russo to diagnose and/or treat my child's dental condition. I understand that I will be responsible for any charges incurred on this child for dental treatment. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Russo will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

Signature: ____ Date:______________________

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards, emails or letters).

Patients Rights

Access: You have the right to look at or get copies of your health information. If you request copies we will charge you for each page for staff time to locate and copy the information, and postage if you want the copies mailed.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.
Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means
Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information you may submit a written complaint to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact Dr. Russo.

Non-Guardian Consent

I give my permission for the following person(s) to accompany my child to his/her dental visits. All person(s) listed below must be over the age of 18. This includes making decisions regarding treatment that may arise during the scheduled appointment. This also gives Dr. Russo and her staff permission to discuss treatment and conditions with the person(s) listed below. I understand that I am responsible for payment at the time of services and should someone accompany my child other than myself, arrangements for payment must be made ***before the scheduled appointment time***.

Name	Relationship to child
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Signature: ______________________________ Date:____________________