Dr. Brian T. Brumbaugh DDS

Pediatric Dentistry

Primary Dental Insurance:

Policy Holder (Name): _____ Relationship to Patient: □ Father □ Mother □ Other

Policy Holder SSN: _____ Policy Holder Date of Birth: _____

Employer: _____ Insurance Company: _____

Phone Number: _____ Mailing address: _____

Secondary Dental Insurance:

Policy Holder (Name): _____ Relationship to Patient: □ Father □ Mother □ Other

Policy Holder SSN: _____ Policy Holder Date of Birth: _____

Employer: _____ Insurance Company: _____

Phone Number: _____ Mailing Address: _____

FINANCIAL POLICY:

Thank you for choosing Dr. Brumbaugh for your child's dental care. Our goal is to provide optimal dental care while incorporating proper dental education which allows kids to remain cavity free. We encourage you to ask questions and be involved in treatment decisions. This includes understanding of any treatment plans as well as our financial policy.

Payment is expected when services are rendered. For your convenience we accept Visa, MasterCard, Discover, and American Express, as well as cash or check. We **DO NOT** provide in-office payment plans. If you are in need of a payment option, please see our insurance specialist about applying for a loan thru CareCredit. Any checks returned to our office as Non-Sufficient Funds will be charged a $30.00 fee per check.

As a courtesy to our insured patients, **we file ALL Dental Insurance Plans**, however, ***we are ONLY IN-NETWORK with DELTA DENTAL PREMIER and Guardian!***
Insurance will be filed for all cleaning/exam appointments and you will be billed after your insurance pays for any remaining balance that was not covered. If your child is in need of additional treatment such as fillings, crowns, etc… a **PRE-TREATMENT ESTIMATE** will be provided BEFORE services are scheduled. When arriving for your child's treatment appointment, the out-of-pocket amount will be due. If your insurance has not paid within 90 days of services rendered, you will need to make payment in full to our office and will be reimbursed if/when your insurance pays.

Please indicate your understanding and acceptance of these financial policies by signing below.

Signed: _____ Print: _____ Date: _____

Consent for Services and Guarantor Agreement

By signing this form, I consent to the use and disclosure of my child's protected health information to carry out treatment, payment activities, and healthcare operations. I hereby authorize Dr. Brian T. Brumbaugh and his staff to perform any and all routine dental procedures for diagnostic/preventative purposes. If additional treatment is needed, an estimate will be presented in the form of a proposed treatment plan.

APPOINTMENT POLICY: All patients are seen on a reserved appointment basis. The procedure you are scheduling requires a definite amount of time be set aside with the dentist. This assures the best possible care for your child. As a courtesy our office provides reminders for upcoming appointments. This is done by email, text message, or telephone call. If your contact numbers change, it is your responsibility to provide updated information for your child's account. All appointments must be confirmed by text , email, or verbally with the office, Giving us this courtesy allows us to schedule another patient that needs to be seen, in the event of your cancellation. **ANY APPOINTMENT NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE WILL BE CONSIDERED A BROKEN APPOINTMENT AND WILL BE CHARGED A $35.00 FEE.** In addition, due to the stringent schedule created for Dr. Brumbaugh, late arrivals may result in the need to reschedule your child's appointment.

I, the undersigned; have read and understand the terms of the above policies.

Signed: _____ Date: _____ Relationship to Patient: _____