

Consent for Treatment

I attest that the information I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my information. I request and authorize Dr. Kay L. Wilson, assisted by her dental staff, to perform diagnostic and therapeutic procedures necessary for my child's dental treatment. I understand that Dr. Kay L. Wilson and her staff might use behavior guidance techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.

CONSENT FOR X-RAYS AND FLUORIDE TREATMENT

Dental radiographs (x-rays) and fluoride treatment are performed to maintain the health of the teeth. These procedures are rendered based on the child's needs and dental history as determined by Dr. Kay L. Wilson and in accordance with the guidelines of the American Academy of Pediatric Dentistry and the American Dental Association. **If you have insurance, the fee for the x-rays and fluoride treatment may or may not be a covered benefit and may have a frequency limitation.**

Indicate below which treatment option you prefer:

- I authorize dental x-rays and fluoride treatment as recommended by Dr. Kay L. Wilson based on my child's needs, dental history, and the guidelines of the American Academy of Pediatric Dentistry and the American Dental Association.
- I authorize dental x-rays and fluoride treatment as approved by me at each visit.

I have read and agree to the **Consent For Treatment** and **Consent For X-rays and Fluoride Treatment** and have indicated my choice.

Signature of Parent or Guardian

Date

PAYMENT INFORMATION

Payment is due at the time of service. For those who have insurance, we will gladly submit your insurance claim for you. We do require any deductibles, co-payments, and "estimated" patient portions be paid at the time of service.

We accept cash, checks, debit cards, Visa, MasterCard, & Discover.

Unpaid balances over 60 days will accrue **a monthly fee of \$5**. Balances over 90 days will be turned over to a collections agency. In this event, you will be responsible for all collection and legal fees.

If a check is returned NSF, there will be a **\$35 check return fee**; from that point on, checks will not be accepted. A **missed appointment charge of \$35** may be applied to your account if less than 24 hour notice is given.

I have read and agree to the **Payment Information** listed above.

Signature of Parent or Guardian

Date

AUTHORIZATION AND RELEASE

I authorize Dr. Kay L. Wilson & Associates, P.C. to submit insurance claims on my behalf. **It is my responsibility to review my insurance policy and to understand my specific dental benefits. I further understand that no employee or any other person from Dr. Kay L. Wilson & Associates, P.C. is authorized to advise me as to my insurance coverage or benefits and I will not rely on any statements, even if made, because it is ultimately my personal responsibility to verify and confirm.**

I understand that dental insurance plans are designed to cover only a portion of dental costs and I am responsible for payment of all services rendered to my dependent. In the event my insurance company has not paid their portion within 60 days, the balance of the bill will become my responsibility.

I have read and agree to the **Authorization and Release** listed above.

Signature of Parent or Guardian

Date

PRIVACY PRACTICES

Federal and state law require the privacy of all health information. I acknowledge that I have received the *Notice of Privacy Practices* for my child/dependent.

Signature of Parent or Guardian

Date

Witness

Date



ASSOCIATES IN PEDIATRIC DENTAL CARE
Infants • Children • Teens • Special Needs

Kay L. Wilson, DDS

Diplomate, American Board of Pediatric Dentistry | Fellow, American Academy of Pediatric Dentistry

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