## Dentistry For Children

### COMMITMENT TO OFFICE POLICY

An appointment written in our schedule, with your child's name on it is a bond of trust that we will be here to serve you and that you will be present and on time for that appointment. We will reserve time for your child during our office hours. For all of us, time is important and we do our best to ensure that you are seen promptly. Dealing with small children, as we do, there are no guarantees. We appreciate your patience. Please be assured that your child will also receive the same extra attention if necessary.

As a courtesy to our patients, Dr. Amanjee's staff attempts to confirm appointments the day prior. However, once you have made an appointment, remembering and keeping it is your responsibility. Confirmation is simply a courtesy to you.

No charge will be made for canceled or reschedule appointments provided that **TWO WORKING DAY'S NOTICE** is given so the time reserved for your child may be available to other patients.

**A CANCELED, RESCHEDULE, OR FAILED APPOINTMENT WILL BE CHARGED $75.00 ON YOUR CHILD'S ACCOUNT.**

**Type of Payment accepted in our office ,** Visa, Master, Discover. Checks are accepted has form of payment but will be required to have a **Driver's License.** There will be a **$35.00** charge for all **Returned Checks.**

Our Office will bill your **Insurance,** as a courtesy to you. If your insurance does not pay for service render to your child, It is the parent or guardian of the patient responsibility to pay your account in full. It will then be your responsibility to have insurance reimburse you for the services. Your insurance is a contract between you and your employer or self. It is up to you to keep our office updated on your policy to avoid any delay's or cost to you .

**THEREFORE, OUR OFFICE POLICY IN THIS REGARD IS EXTREMELY FIRM AND FLEXIBLE: Please be present for all your schedule appointments.**
**Remember that if you need to reschedule, please contact us during office hours at (916-780-7890) at least TWO working days prior to the appointment.** In the event of a failed appointment, you will be asked to pay in full for future treatment before we reschedule the failed appointment. Your understanding and compliance is appreciated.

We look forward to accomplishing all of your child's treatment needs in a comfortable and caring environment.

I have read and understand this policy:

Signed:______________________________________ Date:______________________

Patient Name:____________________________________________________________

**927 Reserve Dr. STE B, Behind The Fountains Roseville CA, 95678**
**Tel: 916-780-7890**
**www.toothfairy4u.com**