CUMBERLAND PEDIATRIC DENTISTRY
AND ORTHODONTICS
495 Dunlop Lane, Suite 112
Clarksville, TN 37040
P: (931) 221-0050
F: (931) 221-0052

Financial Statement

I understand that I am responsible for the entire cost of treatment. I further understand that if it ever becomes necessary for this account to be turned over for collection, I am responsible for any collection and/or attorney fees.

Insurance Statement

I authorize the release of any information needed to process my child's insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize payment of insurance benefits directly to the dentist otherwise payable to me.

Disappointment Fee

I understand it is my responsibility to give the doctor at least a 48 hour notice if I am unable to keep my child's appointment. In the event that I do not give the 48 hour notice or do not call and do not show up, the doctor reserves the right to charge a $25 cancellation fee. This will compensate for the time he had reserved to treat my child and was unable, due to lack of notice, to schedule another patient for treatment during that time.

Authorization

I hereby authorize and acknowledge that any scanned/electronic signatures are to be considered an original signature.

Acknowledgement of Receipt of Privacy Practices Notice

I hereby acknowledge that I have received or rejected Notice of Privacy Practices from the office of Children's Dentistry of Smyrna.

Signature of Parent/Guardian:_____ Date:_____