



Sparks Location
2145 Green Vista Dr.
Sparks, NV 89431
775.331.9477

Fallon Location
2152 Reno Hwy. #B
Fallon, NV 89406
775.423.9453

Perry Francis DDS
www.waskids.com



Financial Policies

Good communication about financial responsibilities promotes good relationships with our patients. Please feel free to ask if you have any questions.

- **The person who brings the child is legally responsible for payments. _____ Initials**
- **We can not split payments between two parents.** We do ask that you make payment arrangements if necessary prior to your child's scheduled appointment. _____ **Initials**
- We participate with the following PPO: Diversified, Dental Guard, Delta Dental Premier Only, MetLife, Cigna, Dentemax and United Concordia. _____ **Initials**
- Office visits are payable at the time of service. _____ **Initials**
- If your child requires dental treatment done in the office, we require a \$50 deposit when scheduling. This deposit will be credited towards the co pay for your child's next dental treatment. _____ **Initials**
- If your child requires dental treatment in an outpatient surgery center or under conscious sedation in office, any co pays must be paid prior to scheduling the service. _____ **Initials**
- Please understand that our goal is to provide your child with the best dental care possible. The goal of your insurance company is to control costs. They are not in the business of determining what optimal care is. **Your insurance is a contract between you and the insurance company. We bill your insurance as a courtesy to you. Any treatment fees are estimates only and you may have a balance after insurance pays. _____ Initials**

Any remaining balances after 45 days must be paid. We do accept cash, checks, money orders, VISA, MasterCard, Discover and Care Credit.

Parent/Guardian Signature

Date



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Broken Appointment Policy

Wild About Smiles confirms all of our scheduled appointments as a courtesy. We do have an automated confirmation system that will send out a message 72 hours prior to your child's appointment. We do ask that you please give us at least 48 business hours' notice to cancel or reschedule any routine or operative appointments. If proper notification is not received you may be charged a broken appointment fee of \$53.00 per child, any appointments scheduled with our hygienist will be charged \$75.00 per child.

For our sedation or hospital cases, we do require at least 7 business days to cancel or reschedule. A sedation/hospital fee of \$300 is required to schedule the appointment and will be forfeited if we receive less than the 7 business days' notice to cancel or reschedule.

We understand that life happens and will do our best to be accommodating in certain situations. Please do not hesitate to speak to our front office with any questions. Thank you.

Parent/Guardian Signature

Date



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 08/01/2007, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event



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of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices,

 Please Print Name

 Signature

 Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify) _____