**Pediatric Dentistry of Reston**

Neda Kalantar, DDS, PLLC

Payam Amirsayafi, DDS

Sana Zaidi, DDS

**Consent for Services**

- I authorize the doctor or staff to take x-rays, photographs or any other diagnostic aids deemed appropriate by doctor to make thorough diagnosis of patient’s dental needs.

- I authorize the doctor to perform all recommended treatment mutually agreed by me and to use appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent the doctor to choose and employ such assistance as deemed fit to provide recommended treatment.

- I understand that all responsibility for payment for dental services approved in this office is due and payable at the time of services are rendered unless other arrangements are made.

- I understand that if there is a balance on my account that I may be asked to make a full payment to avoid charges.

- I understand that my insurance is a contract between myself and the insurance company. Pediatric Dentistry of Reston is not part of that contract. I do not hold the office responsible for any deductibles, co-payments, covered or non-covered charges, “usual and customary” charges, etc. other than to supply factual information regarding services rendered. If I have any questions or disputes I will contact my insurance company.

- I authorize this office to obtain any medical information about my child. I understand that this information will be kept in absolute confidence.

- I have been shown a copy of Pediatric Dentistry of Reston’s Notice of Privacy Practices and understand I can request a copy.

- I give consent to use and disclose my child’s protected health information to carry out treatment, payment activity, and healthcare operations.

- I grant permission for this office to telephone me at home or at my work to discuss matter related to my child.

- I authorize this office to post pictures and videos of my child on social media including, but not limited to, Facebook and Instagram. If I choose to opt out, I will notify the staff promptly to ensure my child is properly noted to abstain from social media posts.

**Cancellation/Reschedule Policy**

In continuing our commitment to your child and his/her oral health we are pleased to reserve appointment times that are convenient for you and your family's schedule.  In order to provide all patients with times that are convenient for their schedules and appropriate for their ages as well as effectively run our dental office, we must maintain those reserved scheduled times.  We will be happy to assist you with rescheduling appointments with at least **48 hour** notice of change or cancellation.

If your child is not able to make it to his/her appointment at the scheduled date and time, please contact our office as soon as possible to determine if we can still see you or if we have another time that day that would work better for you.  Arrival that exceeds 15 minutes past the scheduled appointment time will need to be rescheduled in order to ensure that your child receives the best dental care.  We want to give everyone the same amount of time for their dental care by meeting their scheduled appointment time.  Our staff strives to respect your time and do our part to care for your child in a timely manner.

Appointments are reserved exclusively for your child.  If you must cancel or reschedule on the day of your appointment there will be an **$85** cancellation/rescheduling fee due to the late notice.  We understand that circumstances occur that may not allow allow your child to make a scheduled appointment. Nevertheless, we ask for sufficient notice before a missed appointment, whether 48 hours or less. Exceptions and fee waivers will kindly be determined upon the discretion of our front office staff.

*I have read the above conditions of treatment and payment and agree to their content.*

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**Patient Name(s)**

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**Parent or Guardian Signature Date**