Wright Smiles
Pediatric Dentistry

Patients Name: _____

If your child has to be treated in the operating room, there are 3 areas of service involved.

1.) **Cincinnati Children's Hospital Medical Center-** you may receive a bill from the hospital for the costs of the operating room and supplies. This service is only considered under your medical insurance. Most medical insurances require a prior authorization. Therefore, we must have your current medical insurance information prior to surgery being scheduled. Some medical insurance still may not cover this bill because the surgery is for dental procedures.

2.) **Anesthesiologist-** you may receive a bill from the anesthesia group for the anesthesiologist and supplies. Again, this service is only considered by your medical insurance. A prior authorization may also be required. Therefore, we must have your current medical insurance information prior to surgery being scheduled. Some medical insurance still may not cover this bill because the surgery is for dental procedures.

3.) **Wright Smiles Pediatric Dentistry-** you may receive a bill from us. Our services are only considered under your dental insurance. We must have your current dental insurance information prior to the surgery being scheduled. Included in our fees is the doctor's hospital call charge for the doctor to complete treatment outside our office. This charge along with any estimates must be paid prior to scheduling. Most insurance companies do not consider the hospital call charge for payment. In the event they do cover any portion of the hospital call charge, and a refund is warranted, we will reimburse you.

If you have any questions about any statement you may receive other than Wright Smiles Pediatric Dentistry please contact the appropriate office for your concerns and or questions.

If your child's surgery appointment must be cancelled, for any reason, you are required to give our office a 48 notice. If the notification is not given, we reserve the right to charge you for a missed appointment.

***1 have read the above and understand this proposed information.**

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Witness Initials: _____ **Date:** _____ / _____ / _____

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www.wrightsmilespediatricdentistry.com