Gary D. Sabbadini, D.D.S., A.P.C.

Dentistry for Children & Young Adults

Diplomate, American Board of Pediatric Dentistry
Fellow, American Academy of Pediatric Dentistry
Fellow, International College of Dentists
Fellow, Pierre Fauchard Academy

DENTAL TREATMENT AGREEMENT

Patient Name: _____ Date: _____

- We, the undersigned, acknowledge and understand the treatment plan, including all dental work and medications being given to our child, treatment expectations, and treatment fees that have been presented to us by Dr. Sabbadini and/or his employed staff. We agree that the treatment plan was explained to us to our satisfaction, that we were encouraged to ask questions, and that all our questions were answered to our satisfaction. We also understand that if we should have any further questions that we are encouraged to contact Dr. Sabbadini and/or his staff for answers.

- Because of the amount of time being set aside to treat your child, we require that payment arrangements be made for the total cost of treatment before the appointment. You will be given an estimate for the full treatment based upon the doctor's examination. This estimate may change if your child's treatment changes. If you have insurance, our office will provide billing as a courtesy and will wait for insurance payment for up to 75 days. Your estimated co-payment is due at each dental visit. You are responsible for any remaining balance that is unpaid by your insurance company as previously outlined on your Financial Arrangement form.

- Pre-Payment & Deposit Policy: It takes great effort, time, and coordination to schedule our patients. Therefore, we require that a deposit of $50 or more (depending on the amount of time set aside) be paid prior to scheduling your child's treatment appointment. This deposit is part of your estimated co-payment and is non-refundable. Your child's estimated co-payment is due the day of your child's appointment. You are required to give our office at least 48 business hours notice prior to rescheduling your child's appointment. If we are not provided this courtesy, you may forfeit your entire deposit.

- We understand that we are not to leave the office during our child's appointments unless authorized by Dr. Sabbadini. This is to ensure that Dr. Sabbadini and/or the office staff are able to inform you of any treatment changes and get your written consent should anything change during your child's appointment. We also don't want your child to have to wait for you should we get done early.

- We acknowledge that the patient listed on the "Patient Name" line above is the patient in question and that we are the patient's parents and/or legal guardians.

- We acknowledge that we have been informed that the ***California Dental Materials Fact Sheet*** is available to read/download on the office website at www.PinolePediatricDentist.com.

- We acknowledge that we have been informed that the ***Notice of Privacy Practices*** is available to read/download on the office website at www.PinolePediatricDentist.com.

_____ Date: _____

Parent or Guardian Signature

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