

**MARY PAIGE HUXFORD, DMD, PLLC**

TAMMI LOCKHART, DMD

**PEDIATRIC DENTISTRY**

100 Brandon Road, Suite W  
Starkville, MS 39759  
Phone (662) 323-9726  
Fax (662) 323-9727

## **OFFICE POLICY FOR NEW PATIENTS**

PLEASE READ OUR OFFICE POLICY CAREFULLY AND SIGN BELOW

### **INSURANCE**

We are **NOT** a participating provider for any insurance plan. We do file your insurance as a courtesy. A **\$50.00** payment is expected on your initial visit if there is no established account. If no treatment is needed, any credit balance will be refunded to you after payment is received from your insurance company. If treatment is needed, we will leave a credit balance on your account to help cover the deductible. All future visits will be filed to your insurance and **you are asked to pay your estimated portion not covered by insurance at time of service.** Any remaining balance will be billed to you.

**\*\*\* FOR INSURANCE THAT PAYS TO SUBSCRIBER, PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE, AND INSURANCE WILL REIMBURSE YOU\*\*\***

### **SELF PAY**

Payment **in FULL** at time of service is expected unless prior arrangements have been made.

### **MEDICAID**

We accept new patients needing dental work covered by the Mississippi Medicaid program for children ages five and younger. Children ages six and older may require a doctor referral. After treatment is completed and the child is cooperative enough for care from a general dentist, the patient may be **referred back** to a general practice.

### **CHIP**

Children covered by the Mississippi Children's Health Insurance Plan (CHIP) will receive a treatment plan detailing the treatment needed by the child. CHIP has a yearly maximum allowable of **\$2,000**. **Any treatment that goes beyond this maximum, or treatment that is not covered by CHIP is due from the parent/guardian on the date of service.** There is no co-pay for dental.

**BROKEN APPOINTMENT POLICY, PLEASE READ:** Our office calls to confirm appointments prior to the scheduled date. This is a **courtesy** provided by our office, and occasionally we are unable to make contact. It is the parent/guardian's **responsibility** to remember appointment times. If you can not keep an appointment that has been scheduled, a 24-hour notice is requested. If we receive **no notice** that an appointment can not be kept, it will be considered a **broken appointment**. After **three** broken appointments you may be asked to transfer to another dentist, or a broken appointment fee may be charged.

By signing below, I hereby state that I have read and understand this office policy, that I have been given an opportunity to ask any questions I might have, and that all questions have been answered in a satisfactory manner.

**Guardian's Signature** \_\_\_\_\_ Date \_\_\_\_\_