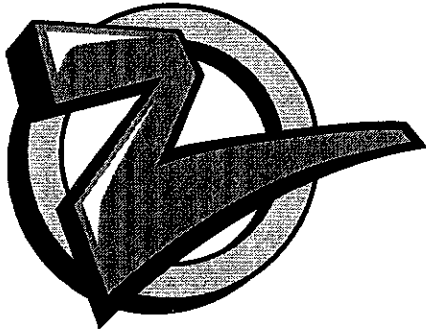


ZOOKA! AGENT-IN-TRAINING FORM



WELCOME TO ZOOKA!

Our mission is to prevent tooth decay before it happens.
We strive to educate you and your child on healthy oral care practices so that your child's super hero smile lasts a lifetime!

TELL US ABOUT YOUR CHILD

Child's Name _____
 Child's Birthdate ____/____/____ Child's Age ____
 Nickname _____ Male ____ Female ____
 Child's Home# (____) _____
 Child's Home/ Mailing Address _____

 City State Zip
 Emergency Contact (other than parent) _____

 Relationship Phone
 How did you learn about Zooka!? _____
 Siblings seen by us? _____
 Previous/Present Dentist _____
 (Please Circle)
 Last Dental Exam _____

TELL US ABOUT YOU

Mother ____ Step Mother ____ Guardian ____
 Name _____
 Mailing Address (if different from child)

 Employer _____
 Work# (____) _____ Ext ____ Home# (____) _____
 Cell# _____
 Email Address _____
 SS# _____ Birthdate ____/____/____

TELL US ABOUT YOU

Father ____ Step Father ____ Guardian ____
 Name _____
 Mailing Address (if different from child)

 Employer _____
 Work# (____) _____ Ext ____ Home # (____) _____
 Cell# _____
 Email Address _____
 SS# _____ Birthdate ____/____/____

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____
 Insurance Co. Phone# (____) _____
 Group# (Plan, Local or Policy #) _____
 Policy Owner's Name _____
 Relationship to Patient _____
 Policy Owner's Birthdate ____/____/____ SS# _____
 Policy Owner's Employer _____
 Employer's Address _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____
 Insurance Co. Phone# (____) _____
 Group# (Plan, Local or Policy#) _____
 Policy Owner's Name _____
 Relationship to Patient _____
 Policy Owner's Birthdate ____/____/____ SS# _____
 Policy Owner's Employer _____
 Employer's Address _____

ZOOKA! FINANCIAL POLICY

Our mission is to provide the highest quality dental care. We greatly value our relationship with you and your child, and strive to keep you well informed of our practices and policies. This also ensures a smooth and pleasant checkout every visit.

Highlighted below is a brief overview of information that you need to know about our financial policy prior to your child's visit. If you have any questions, please talk with any of our front office Zooka! agents.

1. Full payment of your estimated patient portion/responsibility is due at the time of treatment by whomever accompanies your child.
2. We accept cash, check, and major debit/credit cards.
3. Upon approval, and prior to treatment, financing is available through Care Credit, Capitol One Healthcare Finance and American General.
4. Non-sufficient funds (NSF) checks and NSF fees will be debited from your account electronically.
5. If accurate information is provided and insurance is verified, we will bill your insurance as a courtesy.

Further details of the above numbered points are as follows:

1. Full payment of your estimated patient portion/responsibility is due at the time of treatment by whomever accompanies your child.
Please note: the parent, grandparent, or guardian/caretaker accompanying the child is responsible for full payment at the time of treatment.
This policy also applies in cases of custodial vs. non-custodial parent responsibility. If a non-custodial parent is responsible for dental care costs, then payment at time of service must be arranged prior to treatment.
2. We accept cash, check, and major debit/credit cards.
We accept the following forms of payment:
Option A: Cash, check*, or money order
Option B: Credit Card – Visa debit/credit, MasterCard debit/credit, Discover, American Express
3. Upon approval, and prior to treatment, financing is available through Care Credit, Capitol One Healthcare Finance and American General.
Payment plans are available through Care Credit, Capitol One Healthcare Finance, and American General. (Information packets/applications are available at the front office.)
4. Non-sufficient funds (NSF) checks and NSF fees will be debited from your account electronically.
*All checks returned due to non-sufficient funds (NSF) or closed accounts will be processed through No Bad Checks. No Bad Checks will electronically debit the face value of the NSF check and a \$25 NSF fee from your account when funds become available. No Bad Checks will forward any uncollected amounts to a collection agency.
5. If accurate information is provided and insurance is verified, we will bill your insurance as a courtesy.
If you provide us with complete, current, and accurate insurance information, we will bill your insurance as a courtesy. At the time of treatment, we will estimate and collect, from you, your deductible and patient portion/responsibility (according to the information that we have verified with your insurance company). Please note this amount is only an estimate and you are responsible for all amounts not covered by your insurance company.

Most insurance companies base their benefits on UCR (usual, customary, and reasonable) fees. These fees reflect the benefits your employer has chosen and do not reflect the fees charged by us or other dentists in this area. We do not have control over your insurance company's interpretation of their responsibility in paying your bill or the length of time it takes for them to pay. We cannot accept responsibility for reprocessing a claim after 60 days or for negotiating a disputed claim. Upon notification from the insurance company of a denial or dispute of the submitted claim, or if a claim is outstanding for more than 90 days, we will bill the full amount of the claim to you. You must address all questions regarding insurance benefits directly with your insurance carrier or employer.

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE READ THE ABOVE FINANCIAL POLICY AND AGREE TO ITS TERMS AND CONDITIONS. THIS SIGNED FORM ALLOWS US TO PROCESS YOUR INSURANCE CLAIMS, RELEASE MEDICAL/DENTAL INFORMATION TO INSURANCE COMPANIES, AND PROVIDE MEDICAL/DENTAL INFORMATION TO OUTSIDE PROVIDERS WHEN NECESSARY TO COMPLETE TREATMENT.

PARENT/GUARDIAN _____ DATE _____

REVISED 1/16/2006

ZOOKA! AGENT INITIAL _____





ZOOKA! CODE OF CONDUCT

By signing this form, **I understand and agree** that I need to give at least a 24-hour notice to cancel my child's appointment. I understand that the time I reserve for my child could be used by another child, (possibly a child in pain).

By signing this form, **I understand and agree** that if I miss or cancel my child's appointment without a 24-hour notice, a \$25 missed /broken appointment fee will be charged and must be paid prior to rescheduling the appointment.

By signing this form, **I understand and agree** that by committing to keeping my child's appointment, I can make the difference in making sure all Zooka! children are able to have a happy and healthy Zooka! smile.

Child's Name

Parent/Guardian Name(s)

Parent/Guardian Signature(s)

Date

