

Parent Expectation and Agreement Form

Dear Parent,

We are pleased that your child qualifies for StandUp Blue Springs' Dental for Kids program. If you agree to the following terms, Dental for Kids will coordinate your child's treatment.

As the parent/custodial parent/legal guardian of _____, my child and I agree to:

- **Keep all scheduled dental appointments.** If I am unable to keep an appointment, I will call Dental for Kids at least 24 business hours in advance of the appointment to reschedule. The number is 816-478-4500. Business hours are Monday through Friday 9:00 am to 5:00 pm. If my child's appointment is within 24 hours, I will call StandUp Blue Springs **AND** the dentist's office.
 - If my child does not show for an appointment, he/she will be automatically removed from Dental for Kids. Dental for Kids will no longer incur any cost for treatment.
- **Call** StandUp Blue Springs **AND** the dentist's office if I will be late to an appointment.
- **Transport and stay** with my child during all dental appointments. A parent/legal guardian/custodial parent **MUST** take and stay with the child.
- **Comply with the Plan of Treatment as outlined by my child's assigned dentist.** This includes maintaining good oral hygiene habits at home and following dentist directives.
- **Work cooperatively** with my assigned dentist and Dental for Kids staff.
- **Notify Dental for Kids** immediately if my child leaves or graduates from the Blue Springs School District, I obtain dental insurance for my child (Medicaid or private), or there are any changes in information, such as changes in size of household or income.
- **Annually update** my child's information with Dental for Kids to determine eligibility in the program.
- **Refrain from inappropriate behavior** (profanity, threats, violence) towards dental professionals and staff, which is cause for immediate removal from the program.

If the conditions of this agreement are not met, I understand my child(ren) will be removed from the Dental for Kids program and Dental for Kids will no longer incur any cost for his/her/their dental treatment.

Parent Signature _____ Date _____

A signed copy must be returned within one week to the Dental for Kids office. A self-addressed stamped envelope has been provided for your convenience. This copy will be kept in your child's file and updated yearly as a requirement of continued participation in the Dental for Kids program. A copy will be provided to you for your records.



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