A Tooth Doctor for Kids
Pediatric Dentistry

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FINANCIAL POLICY

OVERVIEW OF FINANCIAL RESPONSIBILITY:

Practice Responsibilities: *To submit claims to insurance and statements to the patient/responsible party based on the information provided to us by you. To provide patients with the network and billing information that is available to us.*

Patient/Parent/Guardian Responsibilities: *To understand their own insurance network and benefits. To assure that our office is provided with the most current information known about their insurance and to inform us of any changes in insurance or demographics (address, phone numbers, etc.). To pay within 30 days any balance shown as patient responsibility (e.g. co-payments, share of cost, deductibles and co-insurance).*

PATIENT NAME: ____ DOB: ________________

PARENT/GUARDIAN/
RESPONSIBLE PARTY: ____

DETAILED POLICIES:

(Please Initial)

____ ***Patients must understand their OWN network, plan benefits and plan limitations:***

Your insurance is an agreement between you and your insurance company. All charges are ultimately your responsibility whether you have insurance or not. Not all services are covered under all plans, regardless whether our dentist consider it dentally necessary. Because there are so many insurance plans, it is not possible for us to know the specific details of your coverage. We recommend for you to check with your insurance company to get the details of your benefits, your eligibility and if your plans network includes our office. This way you will be well informed of your benefits and share of costs at our offices. You need to authorize your insurance to pay us directly. We will do our best to check your eligibility and general benefits, but there are no guarantees by your insurance company of those benefits. We do our best in checking your eligibility but failure of our office staff to identify out-of-network plans does not waive your responsibility for payment of services rendered.

If your insurance changes, you must notify us immediately even if you do not yet have your insurance card. It is your responsibility to make our offices aware of your insurance changes a few days prior to your appointment. Insurance coverage may change at the beginning of the year. Every patient elected his or her own insurance coverage and dental plan. A dental plan and its benefits can change year to year based on your employer and/or what a patient may elect. Employers may elect to negotiate benefits at any time thus resulting in changes in your coverage. Only you, the insured, will be notified of those changes.

Insurance benefits vary among dental plans. If requested and as a favor to our patients, we will contact your insurance provider regarding specific procedures. There is no guarantee of coverage over the phone until after submitting completed procedures for payment and an Explanation of Benefits is received. It is up to your insurance company to decide on coverage. We strongly recommend you contact your insurance company to find out about your coverage so there are no surprises. Your insurance coverage and any payment is between you and your insurance company.

____ ***Deductibles, Coinsurance and/or share of costs:***
Any deductible, coinsurance, and/or your share of cost is collected at the time services are rendered. We make an estimation of your share of cost based on what we know about your insurance plan coverage. Our estimation may be more, less or exactly correct. Explanation of benefits sent to you and to us by your insurance company will determine the remaining balance if any.

____ ***Bills are due upon receipt:***
Bills are due upon receipt of mailed statements or you can contact our office and pay by phone with a credit card. Your account balance begins on the day services are rendered (insurance or non-insurance holders). Following 30 days from day of service 18% interest or as allowed by law will be processed for being delinquent. A $50 late payment fee for each month will be added. We recommend contacting the office upon receipt of mailed statements. There is a $25 fee for returned checks.

____ ***Cancellation/No Show Fees***
Appointments are reserved for your child. Out of courtesy for other patients who need appointments, please notify us 48 business hours prior to your appointment. A $50 per patient charge will be made for all failed or cancelled appointments without a minimum of 48 business hours' notice. Exception: All sedation deposits are non-refundable.

____ ***Video/Photo Policy:***
To respect the privacy of our patients, families, doctors and staff, photos and videos are not permitted.

Agreement by patient/parent/guardian: *I have read and understand the financial policies set forth above and agree to them as outlined.*

PATIENT NAME: ____

PARENT/GUARDIAN SIGNATURE____
Date

RELATIONSHIP TO PATIENT____

**** Thank you for taking the time to understand our financial policies ****