FINANCIAL POLICIES AND GUIDELINES

Thank you for choosing our office as your child's dental health care provider. We are committed to providing you and your family with the highest quality dental care. Everyone benefits when office and financial policy arrangements are understood from the very beginning. Should you have any questions or concerns about these policies please see the front desk staff.

Photo ID is required of the parent or legal guardian bringing the child to the first visit.

Payment: Methods of payment that we accept are cash, check, Visa and MasterCard. We do not offer payment plans, however we do accept Care Credit which is a health care credit card that allows you to pay off your balance at your leisure for minimal or sometimes interest free financing. Please ask the front desk staff for more information about Care Credit.

Payment is due at the time of service. If insurance is involved, we ask that you pay the deductible and co-payment, which is the estimated amount not covered by the insurance. We must emphasize that this is only an **estimate** and any charges that are not covered by your insurance will become your financial responsibility. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. In the case of a divorce, regardless of decree, the parent who brings the child and has signed the financial agreement is responsible to pay for the child's services. We are unable to bill separate parties; therefore, parents can work out these details on their own time.

Dental Insurance: Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer, and insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

We recommend treatment based on your child's individual needs, NOT based on what is covered by your insurance company. Our office verifies your insurance benefits as a courtesy to you. Parents/guardians are expected to know their child's insurance benefits prior to their visit. Payment for any services that are not covered at your child's appointment will be collected at time of check-out.

Predetermination: Predeterminations from your insurance company are only estimates. Your insurance company will not provide us a 100% accurate fee until the work is completed and they have received your claim from us. We try to gather as much information as we can to give you an estimate, but please remember that insurance is a contract between you and your insurance company.

Outstanding Balances: Outstanding balances are discouraged and must be cleared before the next appointment for any patient or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amounts due and not paid in full within 30 days will be charged interest at a rate of 1.5%per month in addition to a $5.00 per month billing fee per statement. Delinquent balances over 90 days can be referred to a collection agency and at that point a sensitive relationship with the practice has been established and will result in the patient and family being dismissed from the practice.

Returned Check Fee: Returned checks will incur a charge of $40.00 for each incidence. We regret to inform you that no other checks will be accepted for payment once this has occurred.

Cancelled/Missed Appointments: You dental appointments are scheduled carefully. Time, trained personnel, and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left empty. **We kindly request 48 hours advance notice for rescheduling appointments.** Your account will be charged a broken appointment fee of $35.00 for the second missed appointment without proper notification. Once a third appointment is missed without proper notification, the family will be dismissed from the practice. In an effort to be consistent and fair, no exceptions will be made to this policy. Siblings scheduled on the same day that miss their appointment will no longer be scheduled on the same day moving forward. We do our best to value your time and remain on schedule. If you are running late for your child's appointment, please understand that we may not be able to accommodate you that day. **If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated or if we will need to reschedule you.**

Pictures/Videos: We understand that parents want to document their child's milestones with pictures. Due to patient privacy, we ask that one picture only be taken at your child's first visit without staff or other patients. **Absolutely no videos are allowed at any time.**

All of our patients are minors: As parent or legal guardian, please plan to be present at appointments with your child. You will need staff approval prior to your appointment if someone other than the parent or legal guardian is bringing the child to their appointment. It should be understood that the person accompanying the child is now responsible for all treatment and financial decisions including any day of treatment changes to the treatment plan. This person is also responsible for payment at this appointment. **FOR YOUR CHILD'S SAFETY, ANY PERSON BRINGING A PATIENT FOR TREATMENT IS REQUIRED TO REMAIN IN THE BUILDING THE ENTIRE TIME THAT TREATMENT IS BEING RENDERED.** Treatment can change and someone needs to be available in the waiting room to answer any questions that the staff has regarding your child's visit that day.

Last edited 5/17/18

ACKNOWLEDGMENT OF FINANCIAL POLICIES

I have received and read a copy of the office financial policies and guidelines. I fully understand and agree to these guidelines and have no further questions regarding these policies.

Parent/Legal Guardian Name____

Parent/Legal Guardian Signature ________________________________Date__________

Patient Name(s) ____