Financial Policies

Dentistry for Children accepts several forms of payment for dental treatment provided at this office: ***Cash, debit card, personal check, business check*** (by an authorized person) ***credit card*** (MasterCard, Visa, Discover, some finance company cards)

Dental Insurance: Understanding your insurance coverage can be quite a challenge. Our goal is to provide reasonable assistance to help you maximize your benefits. Most dental insurance excludes coverage for some services, uses restricted fee schedules for most services, and can decline payment based on any number of policy restrictions and limitations. All such restrictions and limitations are based on the premium paid by your employer for the coverage, *not* on our fees or the treatment we recommend. We encourage you to become familiar with your policy: its coverage, exclusions, deductibles and maximums. *We will recommend treatment appropriate to your dental needs regardless of your insurance status.*

Our courtesy service to our insured patients includes:

1) Filing your claims promptly and requesting that payment be sent directly to us.
2) Following American Dental Association guidelines for claims coding and filing.
3) Estimating your benefits to the best of our ability. Most insurance companies will *not* provide us with detailed information about your coverage, so any insurance figures we provide you are only estimates!

Our expectations of you as the insured patient and/or owner of the policy:

1) You will pay, at the time of treatment, all fees not estimated to be covered by your insurance.
2) You will assume responsibility for any amounts expected from you r insurance company but not received within 30 days after treatment has been performed and the claim submitted. Please understand that the insurance policy belongs to ***you*** and we have no leverage to obtain payment from your insurance company.
3) You will authorize us to charge any unpaid amounts to your credit card 30 days after we request payment from you, if payment has not been received. (Exceptions noted below.)

I hereby authorize **Dentistry for Children** to release to my insurance company any information acquired in the course of my dental care. I authorize benefits to be paid directly to **Dentistry for Children**. I understand I am responsible for all fees incurred, regardless of the status of insurance. I understand that treatment cannot be completed until it is paid for (e.g., Space Maintainer,). I authorize **Dentistry for Children** to charge my credit card for any unpaid balances 60 days after treatment has been rendered **Dentistry for Children** can charge any balances not paid within 60 days.

Responsible Party:

_____ _____

Signature Date

Credit card information (Please circle) Visa MasterCard Discover

_____—_____—_____—_____ Expires: _____

Name on card (if different from above): _____

What family members are covered by this agreement? _____

*** **If you fail to notify us within 24 hours, when you need to cancel an appointment, there will be a $75 no show fee. To limit how often we assess this fee, we do require a confirmation call back by noon on the business day before any scheduled treatment appointment or the appointment will automatically be cancelled without a $75 no show fee.**

*****If you write a check to us that is returned NSF by your bank, there will be a fee of $25.**