FINANCIAL POLICY

Thank you for selecting our office as your child's pediatric dental provider. The following is a statement of our financial policy which we ask that you read, understand and sign prior to any treatment.

We are committed to providing your child with the best possible dental care and we are happy to discuss our professional fees with you at any time during our normal office hours. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your responsibility.

Payment is requested at each appointment as service is rendered and can be made by cash, check, MasterCard, Visa, Discover, or American Express. Please be aware that the parent brining the child to our office is legally responsible to payments on all charges. We cannot send statements to other addresses.

DENTAL INSURANCE INFORMATION

As a courtesy to you, our patients, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. We will only accept this assignment of benefits AFTER you are a patient of record with us. In other words, you must pay in full for your child's first visit. Once we have verified your insurance benefits, we will begin filing your claims for you. We estimate what we think with will be and we ask that you pay the remaining balance at the time services are rendered. Once the insurance company reimburses us, if there is still a balance, you will be billed the remaining portion.

You, the parent, are responsible for your entire account balance. If, for some reason, your insurance company does not pay on your claim, you are expected to pay it in full within 30 days of the date of treatment. If your insurance company becomes unduly difficult to deal with, we will ask that you proceed with whatever measures you deem appropriate to collect on your claim.

Please provide us with the following information in order for us to file your claim:

PATIENT'S NAME: _____

EMPLOYEE NAME: _____

EMPLOYEE DATE OF BIRTH: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

COMPANY WHERE EMPLOYED: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY PHONE NUMBER: _____

EMPLOYEE IDENTIFICATION NUMBER: _____

GROUP IDENTIFICATION NUMBER: _____

I authorize the release of any information concerning my child's health care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that I am financially responsible for payments in full of all accounts.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____