

## Financial Policy

Please be aware that the parent bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons. We ask that you pay the cost of the initial exam and any necessary x-rays on the day of that appointment. Please understand that financial arrangements are made directly with you. For the convenience of our patients, the following outlines our financial policy:

1. **Payment is due in full** for each appointment as services are rendered. We accept cash, personal checks Mastercard and Visa. A charge of \$30.00 will be assessed on checks returned for any reason. You will be responsible for payment of all costs and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.
2. **Dental Insurance:** Our office provides in many dental insurance plans. However, the type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, we have no control over the terms of your contract, the method of reimbursement or the determination of your benefits. Any reimbursements by your insurance company other than those we directly participate with should be made directly to you according to the terms of your contract with them.
3. **Pre-treatment authorization:** Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefit is determined.
4. **Fillings:** The main filling material we use in the office is a white (composite resin) filling. Please be aware that your insurance company may not pay for a resin filling at the same level as a silver (amalgam) filling. The co-payment is your responsibility. In some cases, the dentist may recommend placing a silver crown instead of a filling.
5. **Nitrous Oxide (Laughing Gas):** Nitrous oxide is not always covered by dental insurance. We thank you for your payment the date of service.
6. **Appliances:** The entire cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory bills when the appliances are ordered, not when they are completed.
7. **Emergency Treatment:** All emergency treatment must be paid in full at the time the service is rendered.

realize that your insurance coverage is a relationship between you, the patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. You are helping us keep our overhead expenses, in the form of direct and labor costs, down. In addition, you are helping to keep your fees as low as possible. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency. You are to pay any and all attorney fees associated with the collection of monies due.

**I have read and understood my obligation.**

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Dental Insurance Information

Insurance Carrier:

Name \_\_\_\_\_

Primary Policy Holder

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Group/Policy#

Employer of Insured

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Patient ID# \_\_\_\_\_

I authorize my insurance to pay directly to my dentist if my dentist is a participating provider. If I am covered by any other plan, I will pay in full when services are rendered. I understand that all policies are different and I am responsible for knowing my plan provisions. I will be responsible for all co-payment, deductible and rejected charges.

Signature \_\_\_\_\_ Date \_\_\_\_\_

