# FINANCIAL & OFFICE POLICIES

Thank you for choosing us as your child's dental care provider. We are committed to your children's dental treatment being successful. Please understand that payment of your bill is considered part of the treatment. The following is a statement of our office and financial policies, which we require that you read, agree to, and sign prior to any treatment:

- All Parents/guardians must complete our "Patient Health History Form" and "Treatment Consent Form" before seeing the Doctor.
- Full payment is due at the time of service.
- We accept cash, check (in state only) and Visa, MasterCard, AMEX, or Discover & Care Credit plans.
- We do not accept personal checks for payment over $400.

## INSURANCE

We accept assignment of insurance benefits as long as you can go to the provider of your choice. **We do however require the patient portion, deductible, and/or any non-covered service portions of the bill to be paid at the time of service**. The balance due is your responsibility whether your insurance pays or not. We cannot bill your insurance unless you bring in all information necessary to submit a claim. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. As a courtesy, we will attempt to verify your eligibility for benefits under your plan, however verification is not a guarantee of payment for services. You are responsible to know what benefits your child is eligible for. **If your insurance has not paid your account in full within 45 days from the date of service, the balance of your account will be due upon receipt**. Please be aware that your insurance plan may determine some or perhaps all of the services provided to be "non-covered" and not considered reasonable and necessary. Regardless of the insurance plan's determination of benefits you are responsible to pay the full amount charged for services rendered.

Initials: ______

## BILLING

Full payment is due at the time of service. **All accounts which have not been paid 30 days after receipt of statement will incur a $5.00 billing fee each month until the balance is paid**. Any check presented for payment and returned unpaid for any reason will incur a $30.00 returned check fee.

Initials: ______

## COLLECTIONS

Any account that remains unpaid 60 days after receipt of balance due will be sent to a collection agency that will pursue the account guarantor for payment. Additionally, the account guarantor will be responsible for all collection's and attorney's fees and any cost or expense associated therewith.

Initials: ______

## REFUNDS

Refunds for overpayment will be sent after all treatment is completed and insurance benefits have been collected.

Initials: ______

## CHANGES IN SCHEDULED TREATMENT

Due to the uniqueness of treating children's oral health, your child's dental treatment could change very easily. Radiographs may reveal additional oral issues requiring treatment. Necessary changes to treatment will be at the discretion of the Doctor and approved by the parent or guardian. As the account guarantor, you will be responsible for charges for additional services resulting from accepted changes in the treatment plan.

Initials: ______

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APPOINTMENTS

You may make appointments in advance for your child's treatment in our office. As a courtesy, you will be reminded of and should confirm your child's appointments by email, text message, or phone call. You are responsible to ensure that your contact information is updated so that our automated systems will reach you. **If your appointment is not confirmed by you 48 hours prior to the appointment, it will be subject to cancellation**.

Unless your previously scheduled appointment is cancelled by you at least 24 hours in advance, our policy is to charge $30.00 for each missed appointment as an administrative fee. Missed appointments and late cancellations/rescheduling represent a cost to us, to you, and to other patients who could have been seen in the time we set aside for you. Please help our office serve you and other patients better by keeping scheduled appointments. We reserve the right not to reschedule due to frequently missed appointments.

Initials: ______

Thank you for understanding our office and financial policies. Please let us know if you have any questions or concerns. We look forward to providing the highest quality pediatric dental care in a relaxing, fun and caring atmosphere.

**I have read, understand/agree to, and have received a copy the above office and financial policies. I hereby authorize payment of the dental benefits otherwise payable to me directly to KIDZAAM DENTISTRY**.

| Guarantor Name: | |
|---|---|
| Relationship to Patient: | |
| Guarantor Signature: | Date: |
| KidZaam Witness: | |

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