

Child's Name: \_\_\_\_\_

## Little People's Dentistry

### Financial Agreement

Thank you for choosing us to provide your child's dental care. We consider it an honor to have been chosen by you. Our philosophy in serving people is to be informative, honest and forthright. This financial agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our financial agreement please do not hesitate to ask our business office staff.

Dental insurance: As a courtesy we will gladly file your claims and accept assignment of benefits provided you agree to the following:

- You must provide us with an insurance card and all the necessary information to verify your child's coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. WE are **Not** a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which varies from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefits amounts, limitations, exclusions, waiting periods, etc. is entirely **Your** responsibility. Receiving your service indicate your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

#### PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, MasterCard and Discover.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 30 days of the statement date, to avoid finance charges.
- If the insurance company does not pay in full within 30 days, it will be your responsibility to pay the balance within two weeks.
- We don't file claims for medical or more than one dental insurance company per patient.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at the time of visit.

RETURNED CHECKS: A charge of \$35.00 is applied to your account when a check is returned by the bank.

Initials: \_\_\_\_\_

Child's Name: \_\_\_\_\_

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**FINANCE CHARGES AND COLLECTION FEES:** Financial charges will be applied to all balances not paid within 30 days of the service date. A late fee of \$20,00 on the balance unpaid and owed will be assessed each month until the bill is paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid late fees. You agree to pay collection cost and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

**OVERDUE BALANCE:** An account with an unpaid balance past 90 days will be sent to a collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees, and any fees associate with the collection of your debt.

**BROKEN (LATE OR MISSED) APPOINTMENTS:** Appointments not kept or changed with less than 48 hours notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to additional fees. Broken appointments prevent others from receiving the dental care they deserve. We take them very seriously so please be considerate and inform us in advance if you need to change your appointment.

**FEE FOR MISSED APPOINTMENT IF 48-HOURS NOTICE GIVEN:** To reschedule or cancel an appointment, you must notify us at lease forty-eight (48 hours) in advance to avoid a missed appointment fee of up to \$35.00. We reserved the right to terminate professional treatment of any patient when scheduled appointments or not kept.

**RECORDS AND REIMBURSEMENTS:** Original records are the property of this office. If you desire we will provide you a copy of your child's record or radiograph for a nominal duplication of fee.

**SPACE MAINTAINERS AND OTHER APPLIANCES:** All appliances must be delivered within 30 days from the time of impression to ensure a proper fit. If an appliance is delivered after 30 days and does not fit, you will be responsible for an additional fee to remake the appliance. Also, if the appliance is broken or lost by your child you will be responsible for the additional fee to remake it.

**CONSENTS & AUTHORIZATION:** I authorize dental treatment on my child and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office polices and financial polices of Little People's Dentistry. Without any reservations, I agree to abide by the polices outlined herein.

Form completed by:

Print Name: \_\_\_\_\_ Signature : \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Are you the person legally responsible for this child? YES \_\_\_ No \_\_\_

Reviewed by staff member: \_\_\_\_\_ Date: \_\_\_\_\_