

INSURANCE, FINANCIAL & OFFICE POLICIES

Insurance Policies

If your child is covered by your dental insurance plan, it is your responsibility to understand your individual policy. After dental work has been performed in our office, our staff will bill your insurance company as a courtesy to you, based on the insurance information you have provided. We are only able to estimate your financial portion. This payment is due on the date of service. If your insurance pays differently than estimated you are responsible for the unpaid balance. If for any reason your insurance does NOT pay, you are personally responsible for payment of all services. ****Remember that you, not your insurance, are ultimately responsible for payment of services rendered in our office.****

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any other entities that require such information to be submitted.

Financial Policies

I agree to pay the fees charged for the dental services provided by the dentist or his/her assignee at the time the services are rendered. A service charge of 1 ½ % per month (18% annually) will be charged on any unpaid balance exceeding sixty (60) days from the date of service, unless other financial agreements have been made. If a balance is carried on my account for more than ninety (90) days, it will be turned over to a collection agency.

I agree to pay the remaining balance plus reasonable attorney fees, court costs and a 50% collection fee if payment in full for charges incurred is not made. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

This agreement supersedes all prior agreements signed including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care is null and void.

Dental Appointments

I understand that appointments are an agreement and I am responsible to keep all scheduled appointments. If for any reason I am unable to keep an appointment I need to give the office at least **24 - 48** business hours notice (depending on the type of appointment). Any broken appointments will incur a \$25 fee. Surgical center and sedation appointments that are missed will incur up to a \$100 fee. I also understand that if I am late to an appointment it may have to be rescheduled for a different day. I am aware that if I do not come to an appointment I will be charged a broken appointment fee.

I understand and agree to pay the rescheduling/broken appointment fee if I miss an appointment, if I am excessively late or if I do not give the proper amount of notice.

HIPPA Privacy Policies

(Acknowledgement of Receipt of Office Privacy Policies)

I accept Office Privacy Policies

I have read Office Privacy Policies, **but I am refusing to sign** .

I authorize information to be given to a **non-custodial parent** .

I have read and I understand the insurance, financial & office policies and I agree to uphold my responsibilities as previously outlined. I have also read and received a copy of the HIPPA Privacy Policies.

Printed Name

Parent/Guardian Signature

Date