

Financial Policy and Agreement

Insurance:

As a courtesy to our patients, we will gladly file the forms necessary to see that you receive the full benefits of your dental coverage. We ask that you read your policy to be fully aware of any limitations of the benefits provided. *Please note: Many plans have frequency limitations pertaining to a number of the procedures done in our office. These limitations may change from benefit year to benefit year. If you are concerned about coverage for these services, please contact your insurance company prior to your visit.*

If your insurance company denies coverage, or we otherwise do not receive payment 30 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay.

Estimates:

Our practice software enables us to estimate your insurance benefits after the dentist has identified any necessary treatment. In cases where extensive dental treatment is recommended, we will submit a pre-authorization to your insurance company for an estimate of dental benefits. Regardless of estimated insurance coverage, any fees incurred for services received, will be your financial responsibility.

Your Payment is Due at the Time of Treatment:

The estimated uninsured portion of your dental treatment fees is due at the time of service.

Financial Arrangements:

Because we realize that every person's financial situation is different, we provide a variety of payment options.

Payment Options:

For your convenience, the following options are available:

- Cash or check (returned checks will be subject to a \$30 returned check fee. If the check is returned for any reason, your account becomes due and payable within 7 days.)

- Visa/MasterCard/Discover – For your convenience, we have made arrangements to accept payment by Visa, MasterCard and Discover.

- Payment Plan – Arrangements may be made for a monthly payment plan upon request and at the discretion of our Financial Coordinator.

Appointments/Cancellations:

We gladly reserve appointment times for your children and as a courtesy, will attempt to remind you of your appointment by calling and/or emailing you 2 days prior to confirm your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your child's/children's treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

Patient/Parent/Guardian Responsibility:

I understand that whoever accompanies my child to their dental appointment has authorization to consent to dental care as needed, and is responsible for payment of dental services.

I acknowledge my responsibility for payment of all dental services provided by Drs. Liu, Lombardi, and Quinby in accordance with their fees and terms.

In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment. They may then seek reimbursement from the other parent.

I understand that this account becomes delinquent if not paid within 60 days after billing and at that time the unpaid balance will be subject to a finance charge of 18% annually. Any further delinquency will warrant the account being assigned to a collection agency and possibly the addition of further charges.

Assignment and Release:

I authorize payment to be made directly to the dentist by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any dental care information requested by my insurance company.

My signature below acknowledges that I have read and understand this information.

Patient/Parent/Guardian Signature: _____

Name Printed: _ _____

Relationship to patient: _ _____ Date: _____

Staff Member Initials: _____