The Kid's Dentist

Financial Policy

Thank you for choosing our practice for your child's dental care. We are committed to providing the best quality dental care possible and the best service possible. The following is a statement of our Financial Policy, we ask that you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE, THIS INCLUDES ANY INSURANCE DEDUCTIBLE OR COPAYMENT

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

RETURNED CHECKS WILL BE SUBJECT TO A $25 FEE

Regarding Insurance

Your dental insurance policy is an agreement between you and your insurance company. It is your responsibility to give us the most up to date and correct insurance information. Please be aware that some and perhaps all of the service provided may be non-covered services, and therefore are your responsibility. If your insurance company has not paid your claim within 45 days, the balance will automatically be billed to you. You and not your insurance company are responsible for your account. You are expected to pay any estimated portion at time of service. Any balance will be billed to you and payment is expected in full within 30 days. If your insurance company does not pay your claim for any reason, you are responsible for the full payment. In the event of an overpayment, we will issue a refund.

Appointment Information

We set aside time especially for your child's dental care. If you cannot keep your scheduled appointment, we ask for a 24 hour notice. We reserve the right to charge a broken appointment fee of $40 per occurrence if 24 hour notice is not given. Multiple broken appointments will result in dismissal from the practice.

Past Due Accounts

Accounts are considered past due after 30 days. Past due accounts are subject to a late fee of $10 per month. Accounts over 60 days will be forwarded to a collection agency and will also result in dismissal from practice.

I have read, understand and agree to this Financial Policy:

Parent/Guardian Signature: ______________________________________ Date: ___________________

Patient Name: ____