FINANCIAL and APPOINTMENT POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. ***It is our policy to make definite financial arrangements with you before any treatment starts.*** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards (VISA, MasterCard, Discover & American Express, we also offer the Care Credit Payment Plan).

2. If you have an insurance that we participate in we will gladly process your claim. **We request that you pay your <u>ESTIMATED</u> portion when services are rendered. Any amount not covered by your insurance or any difference in the estimated portion is the parent's or guardian's responsibility.** Our office will file your insurance a maximum of **two times** per appointment.

If the claim is not paid by your insurance carrier within 45 days, you will be responsible for the full balance and any further insurance appeal is your responsibility. We will be happy to provide you with a claim form so that you can follow up on your child's insurance claims personally.

3. You must provide the office with a dental insurance card with the proper mailing address of the insurance company. If we are unable to verify your insurance prior to the time of your child's appointment, you will be responsible for payment of all fees.

4. You will be responsible for paying your deductible and co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.** Your insurance benefits are a contract between you and your employer. The amount of coverage you receive will depend on the quality of the plan purchased by your employer, not the fees of the dentist.

5. **The office cannot carry balances longer than 60 days**; regardless if the insurance payment is still pending. A $3.00 monthly re-billing charge will be added to your account if it is not paid within 60 days, regardless of balance amount. After 60 days, we will inform you of the delinquent account by certified letter and if no action is taken to clear the account, this office will be required to employ a collection service to collect payment. The responsible party agrees to pay any attorney and/or collection fees.

6. There will be a $35.00 service charge for all returned checks.

7. **The parent (legal guardian) accompanying the child is responsible for payment.**

We reserve time in our schedule especially for your child and in consideration of others, we request at least 24 hours' notice prior to cancellation of appointments. We do understand that there are circumstances that may prevent you from keeping your child's appointment. However, with providing us as much notice as possible we may be able to contact another family who would like that appointment time. Afternoon appointments fill quickly, and canceling with less than 24 hours' notice does not allow us enough time to schedule another patient in need of treatment. We reserve the right to charge a $50.00 fee for any missed appointment or under 24/hour notice. Patients that are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment.

Patients being seen for restorative treatment may have their appointment rescheduled if they are more than 15 minutes late for their appointment time in consideration for other patients.

Two or more missed appointments or cancelled with less than 24 hours' notice may be subject to limited rescheduling or dismissal from the practice.

AUTHORIZATION

1) **I authorize Parker-Gray Pediatric Dental Care and staff to release any information concerning my child to our insurance company.**
2) **I have read & accept the above Financial and Appointment Policy understand it & agree to the terms set forth regarding payment.**

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Signature of Parent or Responsible Party **Date**