CHILDREN'S DENTISTRY, A PARTNERSHIP

Financial Policy

The ultimate goal of Children's Dentistry, as outlined in our mission statement, is to provide quality care and be understanding to all our patients. We feel confident in our ability to provide you and your child valuable dental care that will exceed all your expectations. Our desire is to establish a long-lasting relationship with you and your child.

Our financial policy is:

We require payment in full at the time the service is rendered. We accept MasterCard, Visa, and Discover, check or cash. We also offer payment plans using our in-house financing program, Care Credit. If you have dental insurance, it is our pleasure to assist you in maximizing your insurance benefits by filing your claims with your insurance company. It is important that you understand that as your dental care provider, our relationship is with you, not your insurance company. The range of benefits depends solely on what your employer wishes to purchase. We will give you an **estimated** amount which is to be paid on the day of service. Most carriers have an 80/20 plan and that is how we **estimate** your payment. If a credit appears on your account, once the carrier has benefited the claim, a refund will be issued to you. Any difference due from you will be due upon receipt of our statement. We can process either the refund or additional charge onto your **debit/credit card** automatically with your authorization.

If for *any reason*, we have not received your insurance carrier's payment **60** days after the claim, the remaining balance will be due and payable by you. Balances over 60 days will accrue a finance charge of 1.5%.

The parent or guardian who brings the child to our office is responsible for payment in full. All statements will be sent to this individual. We will not bill a third party other than insurance companies.

If you have any concerns regarding the financial portion of any treatment plan, please discuss these issues with our financial coordinator prior to when treatment starts. We will not alter our normal financial arrangements once treatment has been done.

☐ I would like more information on **Care Credit.**

☐ I would like more information on using my **debit/credit card.**

☐ I have read the above financial policy and understand my financial options and obligations as described.

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(Responsible Party) (Date)