AllGrins4Kids
Practice Financial Policy

We are pleased to welcome you to our practice. Our desire is to provide your children with the highest quality dental care in a caring and enjoyable atmosphere. It is our policy to make definite financial arrangements with you before treatment begins. Below is an explanation of our office and financial protocols. Please read each item and initial confirming you have read, understand and accept our practice protocols. 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, Visa, MasterCard, Discover and Care Credit.

2. _____For new patient emergency visits we require payment in full at the time of the appointment.

3. _____As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for your reimbursement or you may assign the payment to our office and we will file the insurance for you.

4. _____Our office will file your insurance claim a maximum of **two times** per appointment.

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

6. _____You must provide the office with a dental insurance card with the proper mailing address of the insurance company, or provide a dental claim form, which is provided by the employer. If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.

7. _____If insurance benefits are assigned to the doctor, 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 will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.

8. _____**The office cannot carry balances longer than 90 days;** regardless if the insurance payment is still pending. A one time collection fee of $15.00 will be assessed to your account if it is not paid within 60 days, regardless of balance amount.

9. _____After 90 days, we will inform you of the delinquent account by 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 all reasonable, related collection fees.

10. _____There will be a $30.00 service charge for all returned checks.

11. _____**The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree or custody arrangement may state. Reimbursement must be made between the divorced parents. We will not intervene.**

_____ _____

Signature of Parent or Legal Guardian Date

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