# OFFICE FINANCE AGREEMENT AND POLICY

**Indemnity and PPO Insurance**

We encourage you to familiarize yourself with your insurance benefits. **As a courtesy to our valued patients our office WILL DIRECTLY BILL THE INDEMITY AND PPO INSURANCE** for any treatment. However we do ask our patients to be prepared to make payment toward their basic and major services, including fillings, crowns and extractions at the time these services are rendered. We are Pediatric specialists and our practice is committed to providing the best treatment for our patients. We charge from our own fee schedule which is based on what is usual and customary for specialist in our area. Your co payments will be based on these fees. Once your insurance company submits payment on the claim we will refund any over payment to you or bill you for any remaining balance on your account. Our office will make every attempt to collect payment from your insurance company. In the rare event that your insurance company does not pay within 60 days, the patient's parent or guardian will be responsible for the remaining balance in full.

**Discounted Fee Schedule**

Discounted plans such as Compbenefits and certain Cigna plans are dental plans which allow patients to receive dental services at discounted rates. In accordance with your contract payments in full are required at the time that services are rendered.

**Type of Payments Accepted**

Cash, Checks and all major credit cards (Visa, MasterCard, Care Credit, Discover and American Express).

**Returned Checks**

There is a $50.00 fee for returned checks. Once you have one returned checks from our office we will no longer accept personal checks.

**Scheduling and Cancellations**

Because we value the time spent with our patients appointments that you make are reserved solely for YOU and THE DOCTOR. Please give our office consideration to fill your reservation if you need to cancel. Allow our office at least 24 hours advance notice for cancellation. Any notice less than 24 hours will subject to $25 broken appt fees.

**Collections**

Should there be any remaining balance on my account I agree to pay for services rendered upon notification by a representative of this office. I understand that if my account remains unpaid by me for a period of 30 days it may be outsourced for collections. I agree to pay for all cost incurred including the initials balance plus collection fees, court costs, attorney fees, and interest at 1/5% per month (18% annually).

**MY SIGNATURE BELOW STATES THAT I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES INCURRED AT THIS OFFICE.**

Patient's Name _____ DOB _____

Parent/Guardian Signature _____ Date _____