**Insurance and Financial Policy**

**We believe that your child deserves an Amazing dental experience and the highest quality dental care, which is why we present you with the best dental solutions we have available. The oral healthcare needs and safety of your child will always be our top priority.**

Please read the following office policies:

***For all patients….*** (Please Initial)

_____**We require payment in full for your portion due at the time of service.** We accept MasterCard, Visa, Discover, cash, and check. We do not accept personal checks for over $500.00. A Returned Check Fee of $35 will be charged for any returned or cancelled check.
_____Should an account become delinquent at any time, we reserve the right to charge a 1.5% interest charge on any outstanding balance. Any account that is turned over to collections will also be charged a $55.00 fee.
_____ If you need an extended financing option, we also offer Care Credit, (a third party financing option) who offers 6 or 12 month "same as cash credit line" designed to meet your treatment needs on approved credit.
_____ Appointment times and lengths are specific to each child. We ask that you arrive at your scheduled time to allow treatment planned to be completed. If you must change your appointment time, we require at least 24 hours notice to avoid a $35 rescheduling fee (emergencies are an exception, we just ask that you make us aware).
_____ In the event of a dental emergency after regular office hours a ($55 for current patients and $125 for non-established patients) fee may be charged in addition to the necessary treatment fees.

***For Patients with Insurance Benefits….*** (Please Initial)

_____ Dental benefits are based upon a contract made between your employer and the insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly.
_____ Dental benefit plans rarely pay for completion of all the needed dental care and is only meant to assist you. We currently accept many private care insurance plans and are a preferred or contracted provider with many of them to help assist you with your insurance needs.
_____ The "estimated" portion on your treatment plan is based on the most up-to-date information the insurance company provides us, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to submit a "pre-treatment payment authorization" to your insurance company. Please keep in mind that this is not a guarantee of coverage or payment and may delay treatment, but may give you a more accurate idea of your out of pocket expenses.
_____We bill your Insurance Company as a courtesy to you. However, if your Insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company.

**Ultimately, you are responsible for all charges for any services provided.**

*I understand and agree with the above conditions and policies in place at Amazing Kidz Pediatric Dentistry***.**

Print Name: _____ Date: _____

Responsible Party Signature: _____

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