KIDS DENTAL, P.C. FINANCIAL ARRANGEMENTS, DENTAL INSURANCE, AND APPOINTMENT POLICIES FOR YOUR FAMILY

Kids Dental, P.C. is committed to providing you with the best possible dental care. If you have dental or medical insurance, we are committed to helping you receive your maximum allowable benefits. In order to achieve these goals, we need your understanding of our payment policy, and you must provide a current copy of your insurance cards. **PAYMENT FOR SERVICES IS DUE AT THE TIME THE SERVICES ARE RENDERED**, unless payment arrangements have been approved in advance by our staff. We accept cash, check, and most credit cards. **The parent that brings the child/children in for the appointment is responsible for payment that day (regardless of divorce agreements).** We will process all forms for participating insurance companies where we accept assignment of benefits. We will be happy to help you process your insurance claim form for reimbursement for non-participating plans as a courtesy. Some insurance companies require that you bring in specific insurance forms, which must be completed and signed by the member for reimbursement. **Should any insurance payment be made to the member on this account, I agree to immediately pay these funds to Kids Dental, P.C.** within 30 days. We will gladly discuss your proposed treatment and answer any questions related to your insurance before any treatment begins. Please understand that,

1. Your insurance is a contract between you, your employer, and the insurance company. **Balances are the SOLE responsibility of the member**.
2. Most insurance companies pay on a percentage basis, such as 100% for preventive, 80% for basic, and 50% for major services. **Some insurances have various frequencies for procedures, and therefore are not covered by insurance. You, the member, need to fully understand these terms and agreements with your own dental insurance company. YOU, THE MEMBER, WILL THEN BE RESPONSIBLE FOR ANY DEDUCTIBLE AND/OR COPAYMENTS** up to 100% of the maximum allowable fee set by your insurance company at the time treatment is rendered.
3. Other insurance companies pay on a flat fee schedule whereas deductible and copayments may still apply and would be the member's responsibility.
4. **NOT ALL SERVICES ARE A COVERED BENEFIT**. Any services **not** covered will be the **patient's/parent's responsibility**.

We must emphasize that as dental care providers, our relationship is with you and not your insurance company. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask. Our staff is here to help you.

RETURNED CHECKS AND BALANCES OLDER THAN 30 DAYS ARE SUBJEST TO ADDITIONAL BANK FEES, ATTORNEY AND/OR COLLECTION FEES, AND INTEREST CHARGES. **INITIALS**: _____

DUAL INSURANCE COVERAGE: I understand that the office of Kids Dental, P.C. will submit claims for my primary and secondary insurance plans as a courtesy. I **MUST provide the Explanation of Benefits (EOB) of the primary insurance within 30 days** of receipt so insurance forms can then be submitted to secondary insurance for payment. Also, any checks that come to me will be signed over to Kids Dental, P.C. within 30 days. If these items are not provided to the office, then I take **full responsibility for ALL** payments due for treatment rendered. I also understand that if these items are not provided to the office within the noted time frame that this could affect payments from either insurance plan (possibly resulting in no payment) and understand fully that I will be responsible for all money due for treatment provided by Kids Dental, P.C.

If there are any **alternate arrangements** as to which parent is primary or secondary other than birth date order, such as a **court order**. I will notify the office so that payments from each company are correctly appropriated. **INITIALS**: _____

CHARGES MAY ALSO BE INCURRED FOR BROKEN OR CANCELLED APPOINTMENTS:

Kids Dental, P.C. is committed to providing quality specialized dental care. We ask that you please be respectful of the time that is scheduled for your appointment(s). Our policy requires that you give us, at minimum **24 hours** notice (not including weekends and holidays) if you need to cancel or reschedule your appointment. Failure to do so will result in a **$30.00** fee for HYGIENE appointments and **$50.00** fee for your DOCTOR appointments. If you arrive 15 minutes, or more, late for your appointment, your appointment may have to be rescheduled. **INITIALS**: _____

CREDIT CARD AUTHORIZATION: It is our office policy to obtain your credit card information and authorization to process a claim for payment should your dental health insurance not honor the claim submitted or you have a remainder out of pocket. In providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your dental insurance (including, but not limited to, copayments, deductibles, and/or not covered services), missed appointment fee, and/or bounced checks that cannot be redeposited, and associated bank fees.

Name on Credit Card _____ Billing Zip Code _____

Credit Card Number (Visa/MC) _____ CVV/CID _____ Exp. Date _____

Signature _____ Today's Date _____

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I certify all the information above is accurate and this consent will remain in effect until such time that I choose to terminate it with a written notice. This document applies for my child/children, and I am financially responsible for the financial account**.**

Signature (Parent): X_____ Date: _____