World of Smiles, Pediatric Dentistry
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Financial Agreement

As a condition of your child's treatment by this office, financial arrangements including estimated insurance benefits must be discussed and made in advance. Our office is committed to helping you maximize your insurance benefits. Although you may present us with insurance information, *we cannot guarantee coverage* due to the complexities of insurance contracts. Insurance policies vary greatly from family to family and keep in mind that the relationship is between your family, the employer, and your insurance carrier. As a courtesy to you, we will prepare and file claims for your family. Please note that this financial guideline is subject to change at any time without notice.

Co-Payments: Your estimated patient portion must be paid at the time of service. As a convenience to our patients we offer payment plans through Care Credit and accept Visa, MasterCard, check or cash payments. Any payment from your insurance plan will be credited towards your account. Though we will make every effort to collect payment from your insurance, we are not responsible for how your insurance company handles its claims or for what benefits they choose to pay on each claim. **If, after 60 days your insurance has not submitted payment to our office, you are responsible for the entire balance, paid-in-full.** At that point you are encouraged to pursue the payment from your insurance company.

Appointment Guidelines: We require a minimum of 2 business days notice for **any** rescheduling (a phone message is not considered sufficient notice). While we understand that sometimes situations are outside of your control, we strive to show courtesy to all our patient families, including those who are on a waiting list for your appointment time. Our missed appointment fees are as follows:

- $50 fee for a ReCare appointment that is broken with late notice.
- $75 fee for a Saturday ReCare appointment that is broken with late notice.
- $150 fee will be assessed for broken treatment appointments, and a deposit will be required to schedule future treatment.
- For hospital surgery, conscious sedation, and in-office general anesthesia appointments, broken appointment charges will be assessed at the doctor's hourly rate and may include a rescheduling fee.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay a $50 processing fee, as well as all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all attorneys' fees which we incur plus all court costs. You agree to grant permission for us to telephone you to discuss matters related to

this financial policy or financial arrangements. You agree that charges incurred for services rendered shall be billed at the time of service. Any objection shall be made in writing prior to the start of patient care. You understand that if you default on payment, information to assist in collection of this account may be given to an attorney, collection agency, or professional contracted by the office.

Waiver of Confidentiality: You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you or your child(ren) received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Should the parent holding the insurance for the child(ren) be the party NOT authorizing treatment, the parent authorizing treatment must provide sufficient contact information for the insured parent.

NSF Charge: $25 will be charged if a personal check is returned as "insufficient funds" and a different form of payment will be expected for past balances and future services rendered.

Signature of guarantor of payment/responsible party:
Please note that one adult cannot name another adult as financially responsible. The parent/guardian that signs the financial agreement will be considered the guarantor on the account.

Signature: ____ Date: ___________________________

Relationship to Patient: ____

Co-Signature: ____ Date: __________________________

Relationship to Patient: ____

Reviewed by: ____ Date: _________________________