kids Pediatric Dentistry

"Dr. Lisi"
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FINANCIAL AGREEMENT

Thank you for choosing **Kids Pediatric Dentistry, PA** for your child's dental care! We are committed to your child's treatment being a success. Please understand that payment of your bill is considered a part of your child's treatment and makes it possible for us to remain a viable dental practice. Please read this form carefully and familiarize yourself with the information. A signed financial policy on file is required prior to any treatment. If you have any questions, please do not hesitate to ask.

_____ 1. Payment for treatment is **due at the time services are rendered**. We accept cash, checks, and the following credit cards: Visa, MasterCard, and Discover. Additionally, we are pleased to be able to offer two dental financing options. Both have extended payment plans and offer **0% interest**. The business office will be happy to help you with enrollment.

_____ 2. There will be a $25.00 service charge for all returned checks. Returned checks must be picked up immediately with cash or cashier's check. Unfortunately, we are unable to hold the check for an extended period of time. After a reasonable number of attempts have been made to contact you, the check will be turned over to the **Collin County District Attorney's Office** for legal action.

_____ 3. It is imperative that you provide all the necessary information to file dental claims on your behalf. This will include the insured's personal information, a valid Dental (not Medical) insurance card with a phone number to verify benefits and a correct mailing address. If this information is not available at the time of the appointment or the insurance company can not confirm eligibility, you will be responsible for payment in full at the time treatment is provided.

_____ 4. As a courtesy, we will submit a claim to your dental insurance for benefits. **WE ARE NOT A CONTRACTED PROVIDER WITH ANY DENTAL PLAN; WE ARE CONSIDERED OUT-OF-NETWORK.** Please understand your insurance benefits are a contract between you and your employer. On each visit to the office you will be responsible for deductibles, co-payments, and/or balances not covered by insurance.

_____ 5. The parent or guardian who brings the child for his/her visit is legally responsible for payment independent of what a divorce decree may state. We will not send statements to other persons. Reimbursement must be made between the divorced parents, **we will not intervene.** Please make payments to the office in advance if someone other than the parent/guardian will be bringing your child to the appointment.

_____ 6. Unfortunately, due to Delta Dentals refusal to accept "Assignment of Benefits" on most of their plans, payment in full is required at the time of service. We will continue to file all the necessary claim forms for reimbursement.

_____ 7. The office can not carry balances over 90 days: regardless of insurance. Delinquent accounts can be charged a 1.5% per month or 18% per yr. finance charge. If it becomes necessary for your account to be sent to an outside collection agency or small claims court, please note you will be responsible for all applicable fees, charges and attorney costs.

I acknowledge and accept full financial responsibility for all charges for services or items provided to the minor/child. I understand any insurance estimate given by this office is not a guarantee of actual insurance payment or coverage and understand filing a claim with my insurance benefit plan does not relieve me from my responsibility for the payment of all charges. I assign dental benefits to be paid directly to **Kids Pediatric Dentistry, PA**.

I have read and accept the above financial policy, understand it and agree to the terms.

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Parent/Legal Guardian Date