southeast smiles
PEDIATRIC DENTISTRY

Something for Kids to Smile About

OFFICE FINANCIAL POLICIES

PATIENT: _____

FINANCIALLY RESPONSIBLE PARTY: _____

We are committed to providing you and your child the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to do this, we need your assistance and understanding of our financial policy. The parent/legal guardian accompanying a minor (under 18 years old) is responsible for the full payment. Payment methods are cash. Check, Visa, MasterCard, American Express, Discover, or debit card. Information regarding third party extended payment plans is also available.

NON-INSURED PATIENTS

Full payment is due at the time of service.

REGARDING INSURED PATIENTS (INCLUDING MEDICAID)

The portion of dental service fees not covered by insurance is your (patient or responsible party) responsibility and is due at the time of service. If your insurance company has not paid for rendered dental treatment in full within 60 days, the balance will be your responsibility and due at that time.

We will gladly discuss and answer to the best of our ability any questions regarding the financial aspects of dental treatment. However, please understand:

- At times, your insurance company does not pay for 100% for service. Any discrepancies or questions between your expected insurance coverage, and what the insurance company has actually covered, should be directed to your insurance company.
- Your insurance coverage is a contract between you and your insurance company. The extent of coverage or any other details of that contract cannot be influenced by us.
- We must emphasize that as dental care providers, our relationship is with you and your child. While we file insurance claims as a courtesy to our patients, all charges are your responsibility from the date of service.
- If dental insurance covers all or part of the fee, it may be paid directly to the practice or to the policy holder as arranged. Whatever part of the account balance not paid directly to the practice by an insurance company must be paid by the Financially Responsible Person noted below.

Returned checks will incur an additional $25.00 charge. Balances older than 30 days will be subject to additional collection fees and interest charges of $15 per month. A charge of $30.00 may also be applied to broken or cancellations without a 24 hour advanced notice.

If you have any questions about the above information or the financial aspect of your dental care, please do not hesitate to ask us. We are here to help you.

CONSENT FOR FINANCIALLY RESPONSIBLE PARTY AND CONSENT FOR INSURANCE SUBMITTAL

I hereby consent to the taking of x-rays, photographs and other necessary records before, during and after treatment and to the use of same by this practice for scientific papers and demonstrations.

I authorize the release to my insurance company or companies any information including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for the treatment provided.

RESPONSIBLE PARTY SIGNATURE DATE