



INSURANCE AND FINANCIAL POLICY

At Pediatric Dental & Orthodontics, Inc., we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide excellent dental care to thousands of patients. Some have dental benefits, but some don't. If your family has dental benefits, congratulations! You are very fortunate. Here are some important things all our patients/parents should know:

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_____ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay completely for your children's or your dental care. It is only meant to assist you.

_____ We currently accept most private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment, but will give you a more exact figure.

_____ We will bill your insurance as a **courtesy**. If insurance does not pay within 90 days, Pediatric Dental & Orthodontics, Inc. reserves 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. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ Pediatric Dental & Orthodontics, Inc. does require **payment in full for your portion at the time of service**. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). **We do not accept checks for over \$500.00** for any patient. If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, 12, or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____ I understand a credit history may be obtained.

_____ A specific amount of time is reserved especially for you because you are important to us, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24-hour notice to avoid a \$50 per $\frac{1}{2}$ hour cancellation fee (emergencies are an exception).

_____ In the event of an emergency after regular business hours, a \$55 emergency fee will be charged for established patients, to be paid in cash at the time of service, in addition to the necessary treatment fees. Patients who are not established in the practice will be charged \$125 after hours emergency fee.

_____ I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a **courtesy** to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 24% per annum (2% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 35% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I agree with the above conditions.

Print Name: _____ Date: _____

Patient/Parent Signature: _____