FINANCIAL AGREEMENT & APPOINTMENT POLICY

Welcome to **Dhaduk Pediatric Dentistry**! We are pleased to help your child reach their optimal oral health. In order to make your time with us as efficient and enjoyable as possible, please review our following office policies.

PAYMENTS:

Payment is due **at the time services are rendered**. We accept cash, personal check, and credit/debit card, as well as Health Savings and Flex Spending (HSA/FSA) cards. A $40 handling fee will be charged for each returned check.

DENTAL INSURANCE:

As a courtesy to our families with insurance, our office will file your insurance claims on your behalf. It is your responsibility to provide up-to-date insurance information. Please bring a current insurance card to every appointment. You will be responsible to pay any **ESTIMATED** portion when services are rendered. Any amount not covered by insurance, applicable co-pays, or differences in estimated portions is the **patient's responsibility**.

If an insurance company is unable to confirm eligibility of benefits, you will be required to pay for all services at the time they are rendered. Insurance policies are a contract between you (the policyholder) and your insurance company. **Our office has no control over your benefits** or the amount an insurance company reimburses for a particular service. Insurance companies provide our office with estimates of your out-of-pocket expenses; therefore, it is not possible to give you an exact amount prior to filing a claim.

BROKEN/LATE APPOINTMENT POLICY:

We reserve time in our schedule especially for your child, and in consideration of other patients, we require at least 24 hours' notice prior to cancellation or rescheduling of appointments. There will be a **charge of $50** for **"no show" appointments** or cancellations/changes with less than 24 hours' notice.

If you are running late to an appointment, please contact our office as soon as possible. If you are more than 15 minutes late, will be asked to reschedule.

STATEMENTS:

Monthly statements will be sent to all patients with balances so you will be aware of what payments have been made to your account and what balances are still owed. The first statement will be sent if there is a remaining balance after insurance has made their payment.

You will be given **30 days to make payment** or contact our office with any questions regarding your balance. Account balances over 60 days past due will be assessed a finance charge at a rate of 1.5% of the current monthly balance. If balances are not paid after 90 days, the office may employ a collection service to collect payment.

You understand that if you have an unpaid balance to Dhaduk Pediatric Dentistry and do not make satisfactory payment arrangements, your account may be placed with an external **collection agency.** You will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred in collecting your account, and possibly including reasonable attorney's fees if incurred during collection efforts.

In order for Dhaduk Pediatric Dentistry or our designated external collection agency to service your account, and where not prohibited by applicable law, you agree that they are authorized to:
1. Contact you by telephone at the number(s) you provide, including wireless phone numbers, which could result in charges to you.
2. Contact you by sending text messages (message and data rates may apply) or emails, using any email address you provide.

3. Use methods of contact that may include pre-recorded/artificial voice messages and/or the use of an automatic dialing device, as applicable.

FINANCIAL RESPONSIBILITY:

Financial responsibility falls upon the parent/guardian or accompanying adult who brings the patient to the appointment. **As disclosed, payment is required at the time of service.**

In the case of divorce or separation, the **responsible party prior to the divorce or separation remains responsible** for the **patient's account**. 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.

AUTHORIZATION:

1. I authorize Dr. Dhaduk and staff to accept assignment of benefits and release any information concerning my case to my insurance company.
2. I have read & accepted the above Financial and Appointment Policy, understand it & agree to the terms set forth regarding payment.

Patient's Name: _____

Parent or Responsible Party's Name: _____

Signature of Parent or Responsible Party: _____

Date: _____