pacific pediatric DENTISTRY

Financial Policy

Thank you for choosing our office for your child's dental needs. We are committed to your child's treatment being successful, as they are our first and foremost priority. The following outlines our office policy. We would be happy to answer any questions you may have!

Directions: *Please initial next to each major point, and sign.*

Initial: _____

I am aware that payment of any co-pays or other estimated out of pocket cost is expected on the date of service, unless prior arrangements are made.

If you do not have insurance, your payment will be collected in full at each appointment. In the case of separated households, payment will be collected on the date of service from the parent present at appointment. For complete office policy regarding separated households, please inquire at the front desk. We accept cash, check, VISA or MasterCard as methods of payment for our services. We will be glad to submit all claims and pre-authorizations to your insurance company as long as our office is a participating provider, or accepts your insurance plan. To do this we must have complete and accurate information, as well as a copy of your insurance card. After 60 days any unpaid balances will be charged a 15% late fee for each subsequent billing cycle. Delinquent accounts will be turned over to a collection bureau at the discretion of the office manager. **RETURNED CHECKS:** If checks are returned to our office from the bank, you will be responsible for a returned check fee of $35.00 per check, in addition to the balance due. If payment is not made within 7 days, you may be subjected to an additional late fee.

Initial: _____

I am aware that anything not covered by my insurance, whether or not it was expected, estimated or quoted to me, is my financial responsibility. We do our absolute best to give you an accurate estimate of your insurance benefits. It is important to keep in mind however, your insurance policy is a contract between you, your employer and your insurance company, and you are responsible for any amount that is not covered, or is denied.

Initial: _____

I am aware that there is a $200 charge for missed appointments or appointments canceled less than 72 hours in advance.

We have a 72 hour cancellation policy (business days). **Appointments cancelled less than 72 hours (business days) in advance, or appointments late by 15 minutes or more are considered broken.** With each appointment, time has been set aside specifically for your child. In order to make best use of the doctor's valuable time and not take time away from other patients, we ask that you give us adequate notice if you need to change an appointment.

I have read and agree to the terms set forth in the above financial policy. **I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.**

_____

Signature of Parent or Guardian Date