

FINANCIAL POLICIES

Pediatric Dentistry, P.A. Drs. L. Lee Cope and Susan Fortenberry

Thank you for allowing us to care for your children. We consider it an honor and a privilege and will work hard to give them the best, most fun and compassionate dental experience possible at a reasonable fee. In order to be fair and clear to the patient and the staff at our office we are implementing this Financial Policy.

Our Payment Policy

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. You may use cash, checks, credit cards (Master Card, Visa) and debit cards. Care Credit is available to help finance treatment when cash payment cannot be arranged at the present time.

Initial _____

Insurance Policy

If we have all your insurance information we will help you file your claim for you. If possible we would like to have this information from you before your first visit. When you arrive we will make a copy of your driver's license and insurance card/s for our files. You will be expected to assign the benefits to Pediatric Dentistry, P.A. and it remains your responsibility to pay the copay amount (about 30%) and the deductible (if not met) at the time of each visit. When services are rendered the charges are filed electronically within a few days of the treatment. If there remains a credit or balance after payment is received from the insurance company, a statement will be sent reflecting the balance and payment is expected on a balance or a check will be issued for a credit.

Filing your insurance and accepting your assignment is a courtesy to you. Pediatric Dentistry, P.A. has no arrangement with your insurance company and you are responsible for the complete payment to this office. No insurance will pay 100% of all of the charges or cover 100% of all the fees. Pediatric Dentistry, P.A. does not participate in any group plans.

Initial _____

Pediatric Dentistry, P.A. accepts Medicaid by referral from another physician or dentist and CHIPS. These programs do not cover all procedures offered by our office and do have a calendar monetary limit. These will be the responsibility of the patient if these charges are incurred.

Initial _____

Collections

A finance charge of 1.5% per month will be added to all accounts with a balance over 60 days. A \$25 collection fee will be added to all accounts 90 days or older and turned over for collections. This will be deleted if account is paid in full by 31 Dec 2014.

Initial _____

Appointments

A \$25 no show fee will be charged without a 24 hour cancellation beginning 1 Jan 2014.

Initial _____

I understand and accept the terms of this Financial Policy.

Name of Patient/s _____

Signature of Responsible Party _____ Date _____