FINANCIAL AGREEMENT & APPOINTMENT POLICY

Welcome to Shoreline 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 (MasterCard, VISA, American Express, and Discover), 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 portion 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 time they are rendered. The office will file and accept assignment for only the primary insurance coverage, secondary insurance coverage must be paid directly to the patient. We will gladly provide you with a receipt for secondary insurance filing if necessary. Insurance is a contract between you and your insurance company and our office has no control over your benefits or the amount an insurance company reimburses for a particular service. Insurance companies do not provide our office with exact amounts of your out-of-pocket expenses and it is therefore 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 to 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. We do understand that circumstances may arise that prevent you from keeping your child's appointment, however by providing us as much notice as possible we may contact another family who would like that appointment time. If you are running late to an appointment, please contact our office as soon as possible. If you are more than 10 minutes late, you risk your appointment being rescheduled.

EMERGENCY/AFTER HOURS APPOINTMENTS:

If your child is seen for an emergency visit after our regular business hours, an "after hours" fee is charged in addition to any treatment provided on that visit. All emergency treatment must be paid in full at the time of service.

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 to the office. 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 the 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 currently monthly balance. If balances are not paid after 90 days, the office will be required to employ a collection service to collect payment. You understand if you have an unpaid balance to Shoreline 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 collecting your account, and possibly including reasonable attorney's fees if so incurred during collection efforts. In order for Shoreline Pediatric Dentistry or our designated external collection agency to service your account, and where not prohibited by applicable law, you agree that Shoreline Pediatric Dentistry and the designated external collection agency are authorized to (i) contact you by telephone at the phone number(s) you are providing, including wireless phone numbers, which could result in charges to you, (ii) contact you by sending text messages (message and data rates may apply) or emails, using any email address you provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

DIVORCE:

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. Field and staff to accept assignment of benefits and release any information concerning my case to my insurance company.
2. I have read & accept 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: _____