Practice Limited to Pediatric Dentistry

Financial and Appointment Agreement and Authorization

Financial Policy

We are dedicated to keeping your children's smiles healthy for life. We will do our best to explain all dental procedures and fees prior to beginning treatment. It is our policy to make definitive financial payment arrangements before treatment begins. We offer different payment options to assist in making exceptional dentistry affordable. Regardless of the payment arrangement, the following terms apply:

1) Payment as arranged is due in full at each appointment with cash (exact), check, CareCredit or credit/debit card. Payment plans may be available for up to five months with $100 monthly minimum payments with a credit/debit card on file or post-dated checks.
   a) You must provide 24 hours advance notice to request changes to your scheduled payments under your agreement.
   b) The account balance for a defaulted payment plans will immediately be due in full.
2) If you have dental insurance, we will manage your account as follows:
   a) There is no administrative fee for filing claims; we provide this service as a courtesy.
   b) You must provide accurate insurance billing information, or you will be responsible for payment in full at our self-pay rates.
   c) Treatment estimates are also provided as a courtesy; we do not guarantee benefit estimates to be correct and are not responsible for benefits that are not paid by insurance as estimated.
   d) You are responsible for paying deductibles and estimated co-payments at time of service. You are also responsible for paying all charges not covered by your insurance plan(s), including fees considered above your policy's negotiated fee schedule.
   e) Requests for information to you from your insurance company and/or our practice must be promptly responded to.
   f) We will submit a claim to insurance up to two times per appointment. Further submissions and/or insurance appeals are your responsibility.
   g) You are responsible for insurance balances in full after 60 days, even if your insurance company has not paid and/or an appeal is pending.
   h) Account statements will be mailed for balances above $5 and due upon receipt.
3) Account credit balances from personal payments are promptly refunded by check, after all outstanding insurance claims. If an account credit is below $20, it will remain to be applied towards future services, unless otherwise requested.
4) Overdue balances will accrue monthly billing fees of $12.The practice cannot carry balances longer than 90 days. Delinquent accounts will be notified by letter to avoid collection action. Appointments will not be scheduled for delinquent accounts until paid.
5) A service charge of $30 will be assessed for all returned checks.
6) For patients of divorced parents, the parent signing this agreement will be considered financially responsible, regardless of the divorce decree. We cannot be involved in family financial disputes, including the division of account balances.

Appointment Scheduling

Our office makes every attempt to schedule appointments at convenient times when appropriate, however, in a practice limited to the care of children and teenagers, not all appointments can be made during non-school hours. Our scheduling policies are as follows:

1) For younger patients, morning or early afternoon appointments are necessary. Children are fresher and have more coping resources earlier in the day. We realize this may be inconvenient, but it allows us to provide the highest quality care.
2) Oral/dental issues or pain can greatly reduce a child's ability to concentrate and learn. The best way to maintain good dental health is routine preventive care. This is one of the reasons for mandatory dental exams for Illinois schoolchildren. Consequently, dental appointments are *a legally excused absence* with a signed note from our office.
3) As a courtesy, our office will send a reminder postcard for preventive care appointments the month prior. We will also attempt to contact you via email and/or phone 1-2 days before your appointment(s) for confirmation.
4) If you cannot keep your scheduled appointment, please contact our office ***by phone*** at least 48 hours before your scheduled time, so we can continue to provide quality care on a timely basis and utilize the reserved time for those children who need urgent care or have emergencies.
5) There will be a $25 charge for appointments that are rescheduled more than twice with less than 48 hours advance notice.
6) Any appointments scheduled during non-business hours may be rescheduled during regular business hours if an appointment of the appropriate time/length becomes available.
7) In the event of a dentist's schedule changing, we will attempt to honor the date and time of your appointment with another provider.
8) Arriving ten or more minutes late to a scheduled appointment, may necessitate the rescheduling of the appointment.
9) Our office reserves the right to charge for appointments that are late, missed, or the courtesy of 48 advance notice is not given prior to cancellation. The fees are $75 for 30-minute, $125 for 45-minute, and $175 for 60-minute failed appointments.

Agreement: I have read, understood and accept the financial and appointment scheduling agreement outlined above. I understand that this agreement applies to all patients on my account.
Authorization: I authorize Children's Dentistry Group, LLC staff to submit claims for payment for services to my insurance plans or other benefit programs on my behalf. I assign to Children's Dentistry Group, LLC dental insurance benefits otherwise payable to me. I understand that I am responsible for any and all fees for services rendered. I further understand that if my account is placed with an agency or attorney for Collections due to delinquency, I will be responsible for any associated costs. This financial agreement and authorization shall remain in effect for as long as I receive dental services from Children's Dentistry Group, LLC.

Agreed to and Authorized By:

Printed name of account guarantor and relationship to patient(s)::	*Printed name(s) of patient(s):*
Signature of account guarantor:	*Date:*