HAPPY
PEDIATRIC DENTISTRY

Office Policies

In order to enhance communication and promote understanding regarding this office's financial and missed appointment policy, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies.

DENTAL INSURANCE: We are happy to bill both your primary and secondary insurance carriers as a courtesy to our patients. Please understand that each patient is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you and your insurance company. Keep in mind that all paperwork/information we receive from your insurance carrier with a summary of your benefits states that they do not guarantee payment. Therefore:

- All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits with your insurance company.
- If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to help expedite the claim.
- I understand the doctor will be using white filling material; some insurance companies will reduce the fee to a silver filling rate. It is my responsibility to pay the difference, if any, between the two fees.
- Every 6 months my child will have a full exam, x-rays (if needed), and a prophylaxis/ fluoride treatment. If my insurance does not cover it that often, it is my responsibility to let the staff know before my child goes back for their appointment.
- When scheduling an appointment with oral sedation/laughing gas, I understand that my Insurance may not cover this charge.
- **We will do our best to estimate insurance coverage and patient portions due**. If the insurance does not pay the full amount anticipated, the patient is responsible for the difference.

PATIENT PAYMENT: Payment is due at the time services are rendered. We accept cash, checks, and all major credit cards. We also offer CARE CREDIT as an option. Returned checks will have an additional fee of $25.00 added to the amount of the returned check.

NO SHOW/MISSED APPOINTMENTS: We request a *48 hour notice for cancellation/ rescheduling of checkup/cleaning appointments and 72 hours for treatment appointments.* We understand that sometimes last minute cancellations are unavoidable —individual circumstances may be discussed.

Patient Name_____

Guarantor Name: _____

Guarantor's Signature: _____ Date: _____