Our Office Financial Policy

Thank you for choosing us as your child's dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered part of your child's treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms prior to seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, ALL MAJOR CREDIT CARDS, AND CARE CREDIT WHICH IS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance:

We require that any co-payments, deductible, and any services not covered by your insurance plan, be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you provide all insurance information at the time of your child's initial visit. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware that some, and possible all, of the services provided may be non-covered services and not considered "reasonable, usual, and customary" under the terms of your dental and/or medical policy.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area and specialty. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Our doctors will diagnose treatment based on your child's dental health, not your insurance coverage.

Minor Patients:

The adult accompanying a minor and/or the parent or (guardian) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment plan, credit card or payment of cash or check at the time of service, has been verified.

Payment Plans:

Smiles 4 Kids Pediatric Dentistry has partnered with Care Credit, a patient financing company, to offer interest deferred financing for up to 12 months with credit approval. Pre-arranged credit card agreements may be made with our accounts manager for larger balances.

Refunds:

Refunds for overpayment will be sent after all treatment is completed and insurance has collected.

Collections:

Any account that has not received payment in 90 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment your child can receive at our office
Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.
By signing below, I certify that am the responsible financial party. I have read, understand, and agree to the office financial policy.

_____ _____

Print Name of Responsible Party | Relationship to Patient

_____ _____

Signature of Responsible Party | Date