BEHIND THE SMiLE

DENTISTRY FOR CHILDREN

APPOINTMENT AND FINANCIAL POLICY

WHEN WE WELCOME A NEW FAMILY TO OUR PRACTICE, WE ALSO WELCOME ANY COMMENTS OR QUESTIONS YOU MAY HAVE ABOUT OUR POLICIES. PLEASE READ THE FOLLOWING, SIGN AND RETURN ON THE FIRST VISIT.

An appointment written in our schedule, with your child's name on it, is a bond of trust that we will be here to serve you and that you will be present and on time for that appointment. For all of us, time is important and we do our best to ensure that you are seen promptly. Working with small children, as we do, there are no guarantees. We appreciate your patience. Please be assured that your child will also receive the same extra attention. _____ (initial)

As a courtesy to our patients, we will attempt to confirm your scheduled appointment. Feel free to leave a message on our 24 hour voicemail if you have any questions or concerns. However, once you have made an appointment, remembering and keeping it is your responsibility. Confirmation is simply a courtesy to you. _____ (initial)

We make every effort to be on time, we hope you will also. If you must change an appointment, we request 48 hours advance notice. In the event of illness, call the office as soon as possible. Feel free to leave a message on our 24 hour voice mail. We have many children waiting for earlier appointments. We reserve the right to charge a fee for broken appointments. _____ (initial)

Our office provides dental care as determined by the American Dental Association and the American Academy of Pediatric Dentists. Insurance companies may have limits or exclusions for the recommended treatment. It is up to you to know your insurance policy and any possible limitations and exclusions. _____ (initial)

Payment is requested at the time treatment is provided. We accept most insurance plans and will bill your primary and/or secondary for you. If you have dental insurance we collect the estimated amount not covered at each appointment. You need to provide us complete insurance information and answer any insurance inquiries. In the event of insurance delays or disputed claims beyond 45 days, you will need to pay your account in full and arrange for reimbursement by your carrier. Please remember that insurance companies only assist in payment and rarely cover your full costs. If your dental plan does not pay the amount we have estimated, the balance is your responsibility. _____ (initial)

Finance charges are not assessed on **current** accounts. For accounts 45 days past due, a finance charge will be imposed on services not paid in full. The finance charge is a monthly rate of 1.50%, which is equal to a yearly rate of 18%, with a minimum charge of $1.00. A billing fee is imposed after 45 days at the fee of $5.00 per month. _____ (initial)

A claim will be submitted to my insurance carrier, if applicable, and authorize release of any necessary information to them. I understand that Dr.'s Carolyn, Ashley and Downey are not participating/ preferred providers with my insurance plan and that I am responsible for any balance not covered by such plans. I authorize my insurance company to send payment directly to Murrayhill Pediatric Dentistry P.C. I agree to pay all costs of collections, including, but not limited to, reasonable attorney fees. . _____ (initial)

Method of Payment: _____ Cash _____ Check _____ Care Credit _____ Debit/Bank Card _____ HSA

A $38.00 fee is charged to your account for any bank returned check (NSF). An $85 processing fee will be assessed if your account is deemed delinquent and you will be dismissed from our practice. We will refund any credit back to you as soon as we can. All refunds will be made to the account holder and address we have on file. . _____ (initial)

I acknowledge I have read this financial policy and I am responsible for all charges whether or not paid by insurance. If I have insurance, I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Eric A. Downey, DDS, Carolyn Muckerheide, DDS or Ashley Schaaf, DDS, MPH. 3.10.14

Signature _____ **Date** _____

Print Name _____