PEDIATRIC & ADOLESCENT DENTISTRY

FINANCIAL AGREEMENT
PAYMENT OPTIONS

Payment is expected at the time of service
Personal checks are not accepted for amounts greater than $1000.00

1. Cash or check (5% Courtesy adjustment when charges are paid in full).
2. Mastercard, Visa, American Express and Discover
3. Extended payment plans through CareCredit
4. Pre-payment plan (see Manager)

Dental Insurance

We are prepared to submit your dental insurance claims for you. However, **in order to file your insurance you will need to provide the following**: dental insurance card, subscriber's social security number, subscriber's date of birth, and subscriber's address and phone number.

If you do not have a dental insurance card, you will need to provide the following: name of insurance company, claim address, phone number, group number and member ID/subscriber ID.

We submit a request for pre-treatment coverage by your insurance company. For in office treatment, your co-payment is due on the date of service or an estimate of 30% of the dental fees if we have not heard back from your insurance before the appointment. **We urge you to be fully aware of the limitations of your policy as it may only cover a portion of your treatment.** It is important to remember this is a contract between you and your insurance company and you are ultimately responsible for the total dental bill. In some instances your insurance company's estimate of the amount it will pay changes after we have submitted our bill for payment. If the amount we collect for a co-pay or an estimate of the dental fees is too low you will be billed for the underpayment. If the amount we collect for a co-pay or an estimate of the dental fees it too high, we will return the overpayment to you. This overpayment will be returned in the form of a check from our office. You have 90 days in which to cash the check. If the check is not cashed within 90 days we will continue to hold the amount for a period of three years from the date the check was issued. If you return for service within three years any overpayment will be credited to the services provided by our office. If you request a check after 90 days but before the expiration of three years we will issue a new check for a $25 administrative fee. Any amount not claimed after three years is presumed abandoned and will be sent to the State of Minnesota as unclaimed property.

Hospital Treatment Agreement

Co-payments collected for hospital visits differ from in office co-payments and will be explained at time of scheduling. Co-payments are estimated and you may be responsible for additional charges.

1. For patients covered by insurance, your co-payment is due 2 weeks before the hospital appointment
2. For patients not covered by insurance, the total estimated treatment fees are due 2 weeks before the hospital appointment.

I HEREBY UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES INCURRED FOR DENTAL SERVICES RENDERED BY PEDIATRIC & ADOLESCENT DENTISTRY, LTD.

I/we hereby authorize contact to be made by calling me/us at the preferred telephone number(s) _________________________, including leaving messages, if necessary, concerning collection of this account.

_____________________________ Child(s) name

_____________________________ Child(s) name

_____________________________ Child(s) name

____ **Parent/Legal Guardian**

______________________________ **Date**