Financial Agreement

We appreciate you choosing our office for your child's dental care. In order to build a trustworthy relationship for years to come we want to clarify and agree on methods of payment.
The person accompanying the patient is responsible for the account regardless of who carries the dental insurance. We ask that the person accompanying the child not leave the premises during the appointment in the event that a question arises regarding treatment. **Payment for professional services is due at the time dental treatment is provided**. Every effort will be made to provide a treatment plan which gives your child the best possible care and fits your timetable and budget.

We will be happy to file your claim for you as a courtesy. HOWEVER, WE ARE **NOT** A PARTICIPATING PROVIDER ON ANY DENTAL PLANS. THIS MEANS **YOU ARE RESPONSIBLE FOR THE DIFFERENCE BETWEEN OUR FEE AND THE INSURANCE ALLOWABLE FEE**.

You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. Your insurance company is required to pay or refuse each claim within 30 days of receipt. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 60 days a finance charge of 2% will be added to your account each month until paid unless other arrangements with our office have been made. In case that you pay and your insurance reimburses us later, we will be glad to send a refund to you.

PLEASE UNDERSTAND that we file dental insurance as a **COURTESY** to our patients. We do not have a contract with your insurance company, only you do. We work very hard to assist you in receiving maximum benefits available under your policy, but we are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim; we at no time guarantee what your insurance will or will not do with each claim.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

Payments can be made by credit card, ATM card, cash, personal check, money order or cashier's check.

We appreciate those patients who honor their scheduled time. As much as we understand that emergencies happen, as a courtesy to us and other patients, please allow a 24 hour notice for any cancellations. We do assess a $100 per child fee to those patients who cancel without a 24 hour notice or do not show up to their appointments, as this time the doctor and our team has reserved for you and you only.

I UNDERSTAND AND ACCEPT THE FINANCIAL AGREEMENT OF HEIGHTS PEDIATRIC DENTISTRY AND ORTHODONTICS AND WILL ABIDE BY IT. ALL MY QUESTIONS REGARDING THIS AGREEMENT HAVE BEEN ANSWERED.

Signature_____ Print Name_____

Patient_____ Relationship to Patient_____

Date_____