canton pediatric dentistry

Patient Name (print): _____

FINANCIAL AGREEMENT

Fees incurred for dental services are due in full when services are rendered. We accept cash, personal checks, VISA, MC, AMEX, and Discover. A $26.00 fee will be charged for checks returned from the bank unpaid. A $35.00 fee may be charged for missed appointments and appointments canceled without a minimum of 24-hours' notice. In cases of divorce or separation, the adult who brings the child to their appointment is responsible for any payment due at the time of service.

As a courtesy, we will file your dental insurance on your behalf and accept assignment of payment. Please note, most plans only cover a portion of the cost of dental care. We will ESTIMATE expenses at or prior to each of your visits to our office; however, please be prepared for any deductible, co-pay, or other expenses in excess of the estimates at the time of service. If for any reason your insurance company does not respond with payment within 45 days after service was rendered, the balance will be considered your responsibility and due and payable in full immediately.

Canton Pediatric Dentistry recommends preventive services and treatment based on what we believe is best for your child. We do NOT and CANNOT recommend treatment based on your insurance coverage.

I authorize Canton Pediatric Dentistry to submit insurance claims on my behalf and direct payment of the dental benefits, otherwise payable to me, directly payable to the billing dentist. I understand it is my responsibility to review my insurance policy and to understand my specific dental benefits as well as to confirm coverage and eligibility for services.

I understand that my insurance is currently in-network (initial) _____, or out-of-network (initial) _____.

Initial____ I have read, understand and accept the terms of the Financial Agreement

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

You May Refuse this Acknowledgment

Initial____I acknowledge that I have received the Notice of Privacy Practices for Canton Pediatric Dentistry.

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My signature below indicates that I have initialed the boxes to indicate my elections above.

Signature_____ Relationship to Patient_____

Printed Name of Signer _____ Date _____

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgment
____ An emergency situation prevented us from obtaining acknowledgment
____Other (Please specify) _____