FREDERICK PEDIATRIC DENTISTRY, L.L.C.

Financial / Insurance / Appointment Agreement

PLEASE INITIAL EACH LINE BELOW:

We render our services on the basis that insurance companies may or may NOT pay for all, or a portion of our charges.

_____ **Insurance** – Your insurance policy may or may not follow the American Academy of Pediatric dentistry guidelines. It is your responsibility to know your own coverage and monitor your benefits. If you do not want us to provide the recommended standard of care for your child it is your responsibility to notify us.

As a courtesy, we will be happy to bill your primary insurance carrier for you; however, any co-insurance and any non-participating insurance will be due in full at time of service. Although we attempt to estimate your portion due at time of service, *THIS IS ONLY AN ESTIMATE*. The exact full amount can only be determined after receipt of insurance payments as **we do not take responsibility for verifying your insurance**. In the event that your dental plan determines a service to be "not covered" you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement. If your insurance company requires a referral and-or preauthorization, you are required to obtain it. We will be happy to assist you with any resubmissions up to one time per incidence.

Frederick Pediatric Dentistry, L.L.C. only submits ***dental insurance claims,*** and only accepts insurance payments from dental insurance plans and companies. If you believe treatment or diagnosis should be billed to any other type of insurance, such as your medical, we will provide you with copies of the dental insurance forms enabling you to submit to your medical insurance. Payment from these claims will be sent to you. Additionally, payments for these services are to be paid at the time service is provided.

_____ **Payment –** We accept forms of payment in: Cash, Check, Credit Card and Care Credit. We are pleased to offer a 5% courtesy discount for payment paid in full with Cash only. I understand that I am financially responsible for ***ALL*** charges. I understand that any outstanding insurance balance that is due over 45 days will become *my complete responsibility*. If it becomes necessary to bill you and payment is not received by the due date posted on the statement a late fee of $20.00 will be assessed for each month if an account is not current.

_____ **Returned Checks -** Returned Checks will be subject to a $40.00 processing fee. Please be advised that if your check is returned to us for non-sufficient funds we will only accept Cash and or Credit thereafter.

_____ **Appointments -** Appointments are reserved in advance for your child. Since your child's individual appointment time with the Doctor or Hygienist impacts the medical and dental health of other patients, we require that you give us a 48-hour advance notification for any scheduling change. A broken appointment is an appointment that is cancelled less than 48 hours notice to the scheduled appointment. An arrival of **10 *or more* minutes past the beginning** of the scheduled appointment time by the patient, parent or legal guardian **may be considered a broken appointment.** I acknowledge **there is a fee of $25- $200 for each broken appointment, depending on the type of appointment. Frederick Pediatric Dentistry also reserves the right to cancel any appointments that are not verbally or electronically confirmed within 24 hours of the scheduled appointment.** I further realize that failure to keep this account current, with the exception of dental emergencies, will

not permit additional appointments to be scheduled. **After 2 broken appointments Frederick Pediatric Dentistry has the right to dismiss your child from the practice**.

_____ **Children of 2 Households -** the parent or legal guardian requesting treatment for the child will be held accountable for all charges for services rendered. If the divorce decree requires the non-present parent pay all, or part, of the treatment costs, it is the requesting parent's responsibility to collect from the other partner ***after*** settling their account with Frederick Pediatric Dentistry LLC.

_____ **Delinquent Accounts –** Any account balance exceeding **90 days** will be forwarded to a collection agency. All costs incurred in the collection of unpaid fees will be charged to your account. Delinquent accounts will be reported to the Credit Bureau by the collection agency. If a collection agency becomes involved in the settlement of your account, further scheduled appointments under this account will be cancelled.

_____ **Authorization** - I authorize Frederick Pediatric Dentistry, L.L.C. to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care, to third party payers. I authorize and request that my insurance company pay directly to Frederick Pediatric Dentistry, L.L.C., dental insurance benefits otherwise payable to me. I certify that I have read and understand the policies above. I acknowledge that I have reviewed and have the right to receive a copy of the **HIPAA Privacy Act** to allow Frederick Pediatric Dentistry LLC to use my family's protected health information only to carry out treatment, payment activities and healthcare operations.

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Name of Child/Children

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Personal Representative's Name

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(seal)
Responsible Party and/or Personal Representative's Signature

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Relationship to Patient **Date**