Redwood City Pediatric Dentistry

OFFICE POLICIES

Thank you for selecting our office. We are pleased to welcome your child as a patient. Our practice is committed to providing the best dental treatment possible for children. To prevent any misunderstandings regarding payment for your child's treatment, please review and sign the following policy.

Our office fees are usual and customary for this area. Payment will be expected at the time of service unless prior arrangements have been made. We accept cash, check, VISA, MC, and debit cards.

By signing below, you certify that you and/or your dependent(s), have insurance coverage and assign directly to Redwood City Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered.

Redwood City Pediatric Dentistry may use my health care information and may disclose such information to your insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

This office is not responsible for any insurance company's arbitrary determination of payment, which procedures are covered under the plan, frequency of procedures performed, or period of time taken to process claims. *You are responsible for payment in full regardless of any insurance you may have.* As a courtesy to you, we will complete and file insurance forms relative to dental treatment and will do our best to collect all fees due from your insurance carrier. *However, fees not paid by your insurance company within 60 days are due and payable by the patient's parent or guardian.* The parent or guardian who accompanies the patient is responsible for payment. Any balance over 60 days is subject to a finance charge of 1 ½% per month.

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a $75. We do attempt to confirm appointments, but do so only as a courtesy. Appointment time is reserved specially for your child. The parent/guardian is ultimately responsible for any scheduled appointments made for the child.

The parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

I have read and understand the contents of this agreement. I agree to comply with all policies.

PATIENT'S NAME: _____
(Please print)

PARENT/GUARDIAN NAME: _____
(Please print)

SIGNATURE: _____ Date: _____

Staff Witness: _____