cardinal
PEDIATRIC DENTISTRY

Financial Policy

Welcome to Cardinal Pediatric Dentistry! Please carefully review and sign our Financial Policy outlined below. If you have any questions or concerns about our policies, please ask to speak with one of our team members for more information.

1. Patients with dental insurance must provide accurate and complete insurance information. We will be happy to file for your insurance benefits and submit your claim as a courtesy to you. The individual who signed the treatment plan and/or signed this form is responsible for any portion of payment that the insurance company does not cover regardless of what the treatment estimate lists.

2. Your dental insurance coverage is determined by the contract you signed with your insurance company. What procedures are covered by your insurance and the percentage of coverage you pay for services personally is determined by the contract you signed with your insurance company. This office has no control over the insurance company's payment decisions.

3. Prior to completing any restorative treatment we will provide you with a treatment plan which informs you of the total fee our office expects to be paid for services we plan to perform. As a courtesy, we also estimate how much we expect the insurance company to pay and how much we expect you to pay based on our past experiences working with your insurance company. We cannot stress enough that these are estimates. For exact payment information we recommend you call the insurance company and use the treatment plan provided to determine your exact coverage. When you call the insurance company, we recommend writing down the date, time, and representative's name. Insurance companies frequently provide inconsistent information. Information about your call can help with disputes that may occur regarding coverage after treatment is complete.

4. Your anticipated portion of payment is due at the time of service. These fees may include deductibles, co-payments, and services not covered by your insurance. For your convenience we accept payment in the form of cash and the following credit cards: Master Card, Visa, Discover, and American Express.

5. Disputes over payment are settled based on the contractual agreement between the insurance policy holder and the insurance company. Cardinal Pediatric Dentistry has no power to resolve these disputes and will not get involved in disputes of this nature.

6. Our office will submit your insurance claim at the time of service. We will give a maximum of 45 days from the time the claim was submitted for the insurance company to send payment. After 45 days our office expects payment from the individual who signed the treatment plan and/or the individual signing this form.

7. A statement outlining any remaining balance left after the insurance company has paid their portion will be sent to you via mail or email. Payment is expected at the time of receipt. If payment is not received within 60 days of the date of treatment the account with be sent to collections. A collections fee of 50% of the delinquent balance will be applied to the account if it is sent to collections.

8. We ask that you give a minimum of 24 hours notice if you need to change or cancel your appointment so we can make that time slot available to other patients. If an appointment is missed or cancelled within 24 hours, a $25 missed appointment fee may be applied to your account; if the missed/cancelled appointment is on a school holiday, the fee is $50. If your child's appointment is missed without giving any notice, we reserve the right to discontinue care. We strive to be respectful of our patients and their time by making every attempt to see them at their appointed time. Please arrive on time for your child’s appointment. Our office reserves the right to reschedule the appointment in the event you are tardy. We will try our best to work late arrivals into the schedule if time allows.

I have read and accept the above financial policy. I understand, acknowledge and agree that I am fully responsible for the total payment of all procedures performed. This includes payment for treatment that insurance does not cover.

Guardian's name _____

Guardian's signature _____ Date_____