FINANCIAL POLICY

As a courtesy to our patients, we will file PRIMARY dental insurance claims given we have received all necessary insurance information. We ask that any changes with your insurance or procurement of new coverage be reported to our coordinator prior to your scheduled appointment as some benefits can be time consuming to obtain. **The day services are rendered the presenting parent and/or guardian will be responsible for any estimated patient portion in full. We will not mediate between parents or guardians for payment and expect that the presenting guardian comes prepared for any expected patient portion.** We rely on you to be the expert of your insurance plan and, any remaining balance that remains following the receipt of the claim will be your responsibility. **Please note that our office does NOT file secondary insurance and/or medical insurance.** If you wish to file a claim on your own, we will be happy to provide you with information you might need. *We are currently in-network with* ***Delta Dental, Blue Cross Blue Shield of NC, United Concordia and limited plans with Cigna***.

In addition, your dental insurance is a contract between you and the insurance company. Therefore, we are not responsible for how your insurance company may handle claim payment and/or processing. We are also not to be held responsible for what is or is not covered by your insurance plan. Plan coverage is based off what you have elected, and *every* plan differs. We can only assist you in **estimating** your portion of the cost based off the breakdown provided to us from your insurance company. We will verify your benefits prior to treatment whenever possible. Please note that in providing an *estimate* this means any patient portion you pay at the time of service, does not mean there will not be a remaining balance following your child's services. **In some cases, insurance companies will only send payments to the patient, in which case you will be responsible for paying the entire balance at the time of service.** You will, then, receive a reimbursement from your insurance company directly after the claim is processed.

For your convenience, we accept cash, Mastercard, Visa, Discover, American Express and Care Credit. You, the legal guardian, are responsible for the entire account balance. If, for ***any reason***, your insurance company does not pay your claim, you will be expected to pay it in full **within 30 days of the date of service**. If we have not received your payment within 30 days, further action will be taken. We reserve the right to refer delinquent accounts to a third-party collection agency with an applied interest rate of ***1.5% PER MONTH*** from the date of service.

- I authorize the release of any information concerning my child's dental treatment for the purpose of evaluating and administering claims for insurance benefits.
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for my child's dental services.
- By signing this statement, I agree to be responsible for payment of services not paid, in full or in part, by my dental insurance carrier.

Patient's name: _____**Relationship to Patient:** _____

Guardian's signature _____**Date:** _____

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