

APPOINTMENT AND FINANCIAL POLICY

WHEN WE WELCOME A NEW FAMILY TO OUR PRACTICE, WE ALSO WELCOME ANY COMMENTS YOU MAY HAVE ABOUT OUR POLICIES. PLEASE READ THE FOLLOWING, INITIAL, SIGN AND RETURN AT THE FIRST VISIT. FEEL FREE TO CALL IF YOU HAVE ANY QUESTIONS BEFORE THE FIRST APPOINTMENT. THANK YOU.

APPOINTMENTS:

An appointment written in our schedule, with your child's name on it, is a bond of trust that we will be here to serve you and that you will be present and on time for that appointment. For all of us, time is important and we do our best to ensure that you are seen promptly. Working with small children, there are no guarantees. We appreciate your patience. Please be assured that your child will also receive the same extra attention.

If you must change an appointment, we request two business days notice. In the event of illness, call the office as soon as possible. Feel free to leave a message on our 24 hour voice mail. We have many children waiting for earlier appointments. **We charge a fee of \$50.00 for 'no show' appointments and appointments cancelled without two business days notice.**

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION _____ **please initial**

INSURANCE AND FINANCIAL POLICY:

Our office provides dental care as determined by the American Dental Association and the American Academy of Pediatric Dentists. Insurance companies may have limits or exclusions for the recommended treatment. It is up to you to know your insurance policy and any possible limitations and exclusions. Please advise us before treatment if you do not want certain types of dental care.

Payment is requested at the time treatment is provided. We accept most insurance plans and will submit claims for you if you have provided all required insurance information. If you have insurance, we collect the estimated portion or percentage not covered at each visit. In the event of insurance delays or disputed claims beyond 45 days, you are required to pay your account in full and arrange for reimbursement by your carrier. Our goal is to help you in maximizing your benefits. Please remember that insurance only assists in payment and rarely cover your full costs.

We accept cash, checks, debit and credit cards. Extended payment arrangements can be discussed for follow up treatment. When approved, we have low interest/no interest plans available through CareCredit. Applications for CareCredit are available in our office or online.

Finance charges are not assessed on current accounts. For accounts 60 days past due, a finance charge will be imposed on services not paid in full. The finance charge is a periodic rate of 1.25% per month, which is 15% annual rate, with a minimum charge of \$1.00. A billing fee is imposed after 60 days at the rate of \$5.00 per month. A \$25.00 fee is charged to your account for any bank returned check.

I ACKNOWLEDGE I HAVE READ THIS FINANCIAL POLICY AND I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

SIGNATURE: _____ **DATE:** _____

FOR PATIENTS WITH DENTAL INSURANCE:

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Sunnyside Dentistry for Children, P.C.

SIGNATURE OF INSURED: _____ **DATE:** _____

NOTICE OF PRIVACY PRACTICES-HIPPA ACKNOWLEDGEMENT

We have our Notice of Privacy Practices available for you to view at your first appointment. You will need to sign in the office or if you wish, you may sign now.

I, _____ have reviewed/received a copy of the Notice of Privacy Practices.

signature

date

Please list all children.

