Spotsy Dental Care – Kids and Family

Insurance and Financial Policy

Initial

_____ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. In most instances, a dental benefit plan does not pay the full cost of your dental care. It is only meant to assist you.

_____ We currently accept many private care insurance plans. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_____ We will bill your insurance as a courtesy. If insurance does not pay **within 60 days**, Spotsy Dental Care reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ Spotsy Dental Care does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash and checks (for existing patients with existing payment history). **We do not accept checks over $500.00 from any patient.**

_____ **A $25 monthly late fee** will be charged for any balance not paid within 30 days of a statement due date. **A $35 processing fee** will be charged for insufficient funds or returned checks. In the event my account becomes delinquent due to non-payment and is turned over to an outside collection agency or attorney, I agree to pay all actual and reasonable fees, legal fees, costs, expenses and court costs incurred in order to collect payments due.

I understand and agree to the above policies

Print Name: _____ Date: _____

Patient/Parent Signature: _____

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Cancellation Policy

Initial

_____ When you make an appointment, a specific amount of time is reserved for you with the Doctor. If your appointment with us needs to change for any reason, we ask that you let us know at least **2 business days** in advance. In case of a Monday appointment, we must hear from you by Thursday morning if you want to change your appointment. This is so we can accommodate other patients that may want to come in. We do appreciate your understanding.

_____ In case of a short notice cancellation or missed appointment, we reserve the right to charge **a $35 cancellation fee** and **restrict ability to make future appointments at our office.**

I understand and agree to the above policies

Print Name: _____ Date: _____

Patient/Parent Signature: _____