youngdentistry FOR CHILDREN

FINANCIAL AGREEMENT AND INITIAL DISCLOSURE

The undersigned patient or Responsible Party agrees that the following terms will govern the payment of professional services rendered by the doctors and charged to the patient's account:

_____**(initial)** **Payment for service is expected at each visit.** This includes deductibles, percentages, and treatment not covered by insurance. Patients are responsible for paying all charges not covered by their insurance plans, including all fees considered above their insurance policy's designated fee schedule. The following methods of payment are accepted: cash, check, Visa, MasterCard, Discover, American Express and Care Credit. A service charge of $25 will be assessed for all returned checks. Please allow at least one week to determine your financial options once all necessary information has been received. If payment is not offered or available at the time of the visit, a credit card will be requested to be kept on file for which charges can be made.

_____**(initial)** Because **patients are responsible for the total cost of treatment regardless of their insurance benefits and payments,** we encourage patients to contact their respective insurance carrier to verify coverage. As a courtesy to our patients, we file insurance claims if benefits have been assigned to our office. The coverage a patient receives is not determined by the fees of the doctor, but rather by the plan purchased by his/herself and or employer. Insurance companies will only provide us with a general summary of benefits that are not a guarantee of coverage. Plans that do not accept assignment of benefits to the provider will be required to pay in full at the time of services. **As required by the state, those with active Medicaid coverage MUST see a designated Medicaid provider for care.**

_____**(initial)** To coordinate your insurance benefits, we require patients to provide us with accurate insurance billing information or changes prior to their appointment, or they will be responsible for payment in full**.** Patients with flex-plan benefits must pay for services at the time of visit and can request a receipt for reimbursement. New patient **emergency** visits must be paid in full at the time of service and we can provide an insurance claim form for insurance filing.

_____**(initial)** **Regardless of a divorce decree, the parent, legal guardian, or adult who accompanies the child(ren) for their visit is responsible for payment of the entire patient portion at the time of the visit. Parents and caregivers are expected to coordinate financial arrangements prior to the start of their child's appointments.**

_____**(initial)** Patients may avoid a finance charge by paying the **New Balance** on their account in full within 60 days of treatment completed. Balances over 60 days accrue a 1.5% PER MONTH finance charge. After 90 days, we will attempt to notify patients that their accounts are delinquent before the practice takes collection action. It is agreed methods of contact may include mail, phone calls, text messaging and emails to any address or number that has been provided by you. Additional methods will include use of pre-recorded or artificial voice messaging and/or the use of an automatic dialing device, as applicable. In the event that legal action is required as a result of Responsible Party's failure to pay dental fees due under this agreement, Patient or Responsible Party agrees to pay 100% of all collection costs, attorney fees, and court costs incurred by this office to collect said fees and costs from Responsible Party. Future services may be refused until outstanding balances have been paid in full.

CANCELLED/MISSED APPOINTMENTS

_____(initial) Please provide us adequate notice when cancelling or rescheduling. Any cancelled or failed appointment with less than one business days' notice is subject to a $40 fee per patient. A $50 appointment deposit may be requested prior to scheduling patients with a history of multiple cancelled or failed appointments.

The undersigned patient or Responsible Party acknowledges that he/she has read, understands and agrees to the information printed above and that he/she may receive a copy upon request.

Patient or Responsible Party (print name) _____ Date _____

Patient or Responsible Party (signature) _____ Date _____

REVISED AUGUST 2024