Pediatric Dental Professionals
9015 Mountain Ridge Dr., Houston Bldg, Suite 320, Austin, TX 78759
(512) 346-9771 fax (512) 343-8111

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to your child and regard your complete understanding of our financial policies as an essential element of care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we accept cash, check, Visa, MasterCard, American Express & Discover.

- **Your insurance is a contract between you and your insurance company.** As a courtesy, upon verification of coverage, we will file your insurance claim for you, collecting at the time of service any estimated co-payment, if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

- Our Pediatric Dentists are contracted with Delta Dental Premier & PPO, Sunlife and Blue Cross Blue Shield of Texas. If you are covered by one of these plans, we will bill your plan and will only require you to pay your estimated copayment at the time of service. Any remaining balance would be due upon receipt of our statement.

- All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be "not covered" or over what they deem "usual and customary charges", you will be responsible for this amount. Payment is due upon receipt of statement from our office. If payment is not made upon receipt of our statement, we will no longer file insurance and will expect payment in full at the time of service.

- Your estimated portion of our fees for scheduled hospital procedures is due one week prior to the surgery date. Any balance remaining after your dental plan pays is your responsibility and payment is due upon receipt of statement from our office.

- We will look to the **parent or guardian accompanying** a minor for all services rendered to minor patients.

- In the case of a divorce, regardless of decree, the parent who brings the child is responsible to pay for the child's services. Reimbursement must be made between the divorced parties. **We will not intervene.**

- **APPOINTMENT CANCELLATION POLICY** – We kindly request that you provide us with **24-HOUR NOTICE** should you need to reschedule an appointment. Appointments that are missed or rescheduled LESS THAN THE 24 HOUR required notice will be charged a Cancellation Fee:
  *Cancellation of a Cleaning or Diagnostic Appointment is $25 per child.
  *Cancellation of a Dental Treatment Appointment such as a Filling or Extraction is $100 per child

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

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PRINTED PATIENT NAME **DATE**

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SIGNATURE OF RESPONSIBLE PARTY **DATE**