



# KAYSVILLE Pediatric Dental

## Financial Agreement

- 1. Payment is due in full** for each appointment as services are rendered. If you have dental insurance, we collect your **ESTIMATED** portion. It is your responsibility to know and understand your individual benefits as every plan is different. We are unable to know exactly how much your insurance will cover until we receive payment from them on submitted claims. If your insurance does not cover a portion of the treatment performed, you will be responsible for the balance. We accept cash, personal checks, Visa, Mastercard, Discover and Care Credit. There will be a \$25 returned check fee assessed to your account if returned for any reason.
  
- 2. Dental Insurance:** Our office is dedicated to providing all of our patients with the finest treatment available and base our treatment recommendations on what will be best for your child and not what your insurance company does or does not pay. Please review the following in regards to your dental insurance coverage:
  - ❖ We must emphasize that as a dental care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between you and your insurance company.
  - ❖ As a courtesy, we will file your insurance claims. Any amount determined not to be covered by your insurance is due at the time services are rendered. These fees may include deductibles, co-payments, and procedures not covered by your insurance policies.
  - ❖ If insurance does not pay my claim within 60 days, payment is expected from the responsible party. Service fees of 1.5% per month (18% per annum) will be added on all accounts over 60 days.
  
- 3. Fillings:** Dr. Jones only uses white fillings (composite resin). Please be aware that many insurances will **DOWNGRADE or Pay** white fillings to the silver (amalgam) filling rate. **The difference in cost is your responsibility.**
  
- 4. Past Due Accounts:** If your account becomes past due, we will take the necessary steps to collect this debt. The responsible party agrees to pay all service fees, attorney fees and court costs associated with collecting payment for services rendered. Collection fees of up to 40% are added to the account when it is turned over to an outside agency.

Please be aware that the guarantor that brought the child to our office is responsible for all charges incurred. We are unable to send statements to other parties. By signing below, I verify that I have read and understand the financial obligation and agree to abide by this policy.

\_\_\_\_\_  
Print Name of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Party

