ENFIELD
pediatric dentistry
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Welcome to Enfield Pediatric Dentistry! We thank you for choosing us to care for your child. It is our primary goal and responsibility to provide children with the highest quality dental care. We ask you to carefully review and sign our Financial Policy below. If you have any questions or concerns about our policies, please do not hesitate to speak to one of our staff members.

1. Patients with dental insurance must provide accurate and complete insurance information. We will be happy to file for your insurance benefits and submit your claim as a courtesy to you. If insurance coverage cannot be verified, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.

2. **Our relationship is with you and your child, not your dental insurance company.** Your dental insurance is a contract between you, your employer and the insurance company. The percentage covered for each procedure is determined by how much your employer has paid for coverage and is not related to our professional fees. Our office does not determine your dental benefits. Most plans pay between 50-75% of the average total fee. This is how your co-payment is **estimated.**

3. Prior to completing any restorative treatment, we will provide you with a Treatment Plan which includes our total fee, your **estimated** insurance coverage, and your **estimated** out-of-pocket costs. **Please remember, these are only estimates and may change during the course of treatment.** Sometimes, treatment alternatives become necessary for various reasons, which may increase or decrease treatment costs. Further, most insurances do not tell us exactly what they will cover, so we are only giving you our best **ESTIMATE.** Some insurances do not reimburse dental offices directly. In these rare cases, you will be responsible for the full cost at the time services are provided and your insurance company will send you the reimbursement check directly.

4. **Any amount not covered by your insurance company is payable at the time services are rendered.** These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. For your convenience we accept cash, personal checks, and the following credit cards: VISA, MasterCard, Discover, and American Express. **Any returned checks will incur a $29 service charge.** We cannot accept responsibility for negotiating a disputed claim; we allow a maximum of 45 days for your insurance company to clear account balances. If your insurance company does not pay within 45 days of the treatment rendered, we shall expect payment in full from you. For your convenience, we offer patient financing by CareCredit.

5. Any remaining balance will be billed to you after a claim is paid. **Any balance will be due upon receipt of your statement.** If an account becomes past due, we will be required to employ a collection service to collect payment. In the event your account is referred to an attorney or collection agency, you agree to pay for processing or convenience fees if required as a cost of collection of your account. You understand that such fees would only be incurred if you optionally choose to pay the account by credit card or check by phone to the attorney or agency.

6. Your child is unique and special to us, and appointment times are reserved exclusively for each patient. We ask that you give us at least 48 hours notice so that we may make the time slot available to another patient. We realize that unexpected things can happen, but ask for your assistance with this regard. **A missed appointment fee of $49 may be applied to your account with less than 24 hours notice of cancellation.** Repeated failure to keep your appointments without notice may result in our office discontinuing treatment for your children.

I have read and accept the above Financial Policy. I understand, acknowledge and agree that I am fully responsible for the total payment of all procedures performed including treatment that is not a benefit of any dental insurance I may have.

Print Name of Parent/Guardian	Signature of Parent/Guardian	Date