Palouse Pediatric Dentistry
Karen M. Sept, DMD

Office and Financial Policies

Please initial next to each statement to indicate that you fully understand these policies.

Please arrive on time for your appointments. If you arrive late to an appointment, we may not be able to see you that day and may need to reschedule your appointment. **Repeated tardiness and rescheduling may result in a missed appointment fee of $50.00.**

INITIALS:_____

Our office requires at least 24 hours notice to cancel an appointment. Missing an appointment or canceling fewer than 24 hours prior to a scheduled appointment may result in a $50.00 fee. **Two missed appointments may be grounds for dismissal from our practice.**

INITIALS:_____

A parent or legal guardian must always accompany the child to his or her appointments. Unless we are provided with a signed, notarized court order for our records outlining division of responsibility, the parent who brings the child in for their visit will be considered financially responsible for that visit. Please communicate with our office promptly when legal changes in financial responsibility occur.

INITIALS:_____

Payment is due at the time of treatment. We accept cash, check, debit cards, and major credit cards. We also offer a flexible payment plan, Care Credit, which may allow you to start your treatment today and spread payments out over time. Applying for Care Credit takes only a few minutes and there is no fee to apply.

INITIALS:_____

There is a $35.00 fee for all returned checks. Any account delinquent in excess of 90 days will be turned over to a third party collection agency.

INITIALS:_____

By initialing above and signing below, I acknowledge that I have read and agree to accept the terms of this policy statement:

_____ ____/____/_____

Parent/Guardian Signature Date

This signature will apply for all insurance claims

Patient's Name:_____

Patient's Date of Birth:____/____/_____

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Insurance Billing Policies

Please initial next to each statement to indicate that you fully understand these policies.

It is your responsibility to know your insurance coverage and provide us with the most current insurance information. Remember that your insurance is a contract between you and your insurance company and we are not a party to this agreement. We will attempt to process most patients' insurance, and are in network with Delta Dental, Blue Cross of Idaho, Regence Blue Shield, Cigna, and Dental Health Alliance (DHA).

INITIALS:_____

It is possible that some or all of your treatment may not be covered by your insurance provider or not considered reasonable and customary according to their terms. **The responsibility of payment for your child's dental care is yours.** If your insurance company has not paid the assignment of benefits that we have accepted within 60 days, we will transfer these unpaid claims to your account for payment. **Payment in full is required upon notification.**

INITIALS:_____

As a courtesy, we will submit insurance claims for you. We will assist you in estimating your portion of the cost of service, but we cannot guarantee how your insurance company will handle each claim or for what benefits they pay on a given claim. Please note that insurance companies generally only pay a portion of the bill, and **you are responsible for the payment of your portion of remaining balances after insurance payment.**

INITIALS:_____

If for any reason we are unsuccessful or unable to continue attempting to process your claim for you, we will inform you and gladly provide you with all of the information necessary should you decide to continue pursuing the claim with your insurance company. ***Please do not hesitate to call us with any questions you may have regarding insurance billing.***

By initialing above and signing below, I acknowledge that I have read and agree to accept the terms of this policy statement:

_____ ____/____/_____

Parent/Guardian Signature Date

This signature will apply for all insurance claims

Patient's Name:_____

Patient's Date of Birth:____/____/_____