



colorado kids
PEDIATRIC DENTISTRY, P.C.

specialists in pediatric dentistry
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OFFICE FINANCIAL POLICY

Our office is dedicated to providing optimum oral health care for children. The best dental service is based on a friendly and mutual understanding between the doctors and the families we are privileged to serve. The following information is provided to further our mutual understanding of important financial issues.

Payment

Please be aware that the parent bringing the child to the practice is responsible for the payment of all professional fees. Our office is a fee for service practice and therefore payment is required at each appointment. We accept Visa, MasterCard, Discover, American Express, cash and personal checks. Additionally, we offer *Care Credit* for any families that require a payment plan.

Billing Fee

1.5 % monthly billing fee, \$2.00 minimum, will be charged to all unpaid balances after 30 days from the date of service.

All phone numbers provided to our office; residential, employment, or wireless, are authorized methods of communication by our office, or by a collection agency, in regards to any outstanding collection balances.

Dental Insurance

As a courtesy for our patients with insurance, our office will file your insurance claims. Insurance plans do not cover the full cost of dental services and the patient is responsible for their co-pay portion. We require insurance co-pays for professional services rendered at the time of treatment, as well as any deductibles that have not been met. Please remember that insurance is considered a method of assisting in the cost of care and is not a guarantee of payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. The amount of coverage you receive will depend solely on the type of plan purchased by your employer, not the fees of our practice. *Regardless of the status of an insurance claim, full payment is due to our office within thirty (30) days from the date of service.*

Although an effort is made to determine your benefits, you are ultimately responsible for knowing the specific benefits of your plan, including the frequency and age limitations of your particular plan.

If you have any questions regarding the specifics of your plan, we ask that you contact your insurance company or human resource department.

I have read, understand and agree to the terms of the above financial policies.

Signature of Parent/Legal Guardian

Date

happy kids, healthy smiles!

INSURANCE INFORMATION

Primary Insurance

Name of Insurance: _____ Group #: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Employer's Name: _____ Telephone: _____

Policy Holder Name: _____ Social Security: ____ - ____ - ____

Subscriber ID#: _____ Date of Birth: ____/____/____

Relationship to Patient: _____

Secondary Insurance

Name of Insurance: _____ Group #: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Employer's Name: _____ Telephone: _____

Policy Holder Name: _____ Social Security: ____ - ____ - ____

Subscriber ID#: _____ Date of Birth: ____/____/____

Relationship to Patient: _____

I agree to be responsible for all charges for dental services and materials not paid for by my dental plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I authorize release of any information relating to this claim.

I assign insurance benefits, for services rendered to Colorado Kids Pediatric Dentistry, and authorize Dr's Fox, Wilson and/or Norwood to maintain this signature on file to be used on my insurance submissions, whether manual or electronic.

Signature of Primary Insurance Subscriber

Date

Signature of Secondary Insurance Subscriber

Date