



## OFFICE FINANCIAL POLICY

We appreciate you allowing us to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based upon understanding, we offer these clarifications on methods of payment and insurance reimbursement.

Upon your first visit, we will request a copy of your dental insurance information to allow us to file your claim for this and all future visits. Please remember to bring all dental insurance information, as well as insurance card(s). We also ask that you contact us immediately after making any changes to your dental coverage, so we can keep our records current and to provide expeditious reimbursement of your benefits.

If any treatment needs are discovered during your child's exam, **we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out-of-pocket portion for the treatment plan.** We will discuss all treatment and cost before beginning any further treatment. Please remember, our office is here for you. Feel free to contact us with any insurance or payment questions.

- Payment in full by cash, check or credit/charge card at each appointment as service is rendered is requested. For your convenience, Visa, MasterCard, American Express and Discover are accepted.
- We will be happy to file your insurance claim on the first visit if we have received all of your insurance information. You will need to be prepared to pay any amount that is determined not payable by your insurance plan, such as deductibles and percentages.
- Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out-of-pocket portion (estimated patient portion or EPP). Please remember, this is only an estimate based upon generalized information provided by your dental insurance company. An additional billing or possibly a refund may be subsequently required should information provided be inaccurate.
- The parent or guardian who accompanies the child will be responsible for payment at time of service.
- We are dedicated to providing the best treatment for our patients and our fees are based on the most appropriate treatment for your child and not what your insurance company does or doesn't pay. Please note the following:
  1. We must emphasize that as a health care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between you, your employer and the insurance company. Most plans routinely pay between 50-75% of the average total fee for a given procedure. This percentage is pre-determined by the plan your employer has purchased.
  2. Our office does not determine your dental benefits. Your employer chooses your particular policy. If you are unhappy with it's coverage, this should be mentioned to your employer's benefits coordinator. Only your employer can adjust benefits. Because your dental insurance plan is a contract between you, your employer, and the insurance company, many carriers will not reimburse our office. In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.
  3. Any amount not covered by your insurance company is payable at the time of service, such as deductibles, co-payments or certain procedures not covered by your insurance policy. We allow a maximum of 45-days for your insurance company to clear account balances. Any unpaid portions will be due in full, by you, after this period. If you have not paid your balance within 60 days of the date treatment was rendered a finance charge of 1.5% will be added to your account each month until paid. Should your insurance company submit payment after this time, we will be glad to reimburse you.
  4. You are responsible for payment regardless of any insurance company's arbitrary determination of fees. Please be aware that some services provided may not be covered by your specific dental insurance. Our primary goal is to treat your child using the best possible materials, supplies, medications and environment.
  5. Should your account be turned over for collection, you will be responsible for all costs of collection, without limitation, attorney's fees and court costs.

We will always do our best to maximize the insurance benefits that you are eligible to receive and we appreciate your prompt settlement of any charges that may be incurred during the treatment process. We look forward to years of close association with you, as we work together to maintain your child's oral health!

**I have read and understand the Office Financial Policy and agree to abide by its contents.**

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_



Specializing in Dentistry for  
Infants, Children and Adolescents

# PATIENT REGISTRATION FORM

## TELL US ABOUT YOUR CHILD

Patient's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  Male  
first middle initial last  Female  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
 Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone ( ) \_\_\_\_\_ How did you hear about us?  Yellow Pages  Dr. \_\_\_\_\_  Friend \_\_\_\_\_  
 Drive by  Moore Folder  Other \_\_\_\_\_

## WHO IS ACCOMPANYING THE CHILD TODAY?

Name \_\_\_\_\_ Relation \_\_\_\_\_ Do you have legal custody of this child?  Yes  
 No  
 Emergency Contact (name and phone) \_\_\_\_\_  
 Whom may we thank for this referral? \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ For how long? \_\_\_\_\_  
 SSN# \_\_\_\_\_ Driver's License # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employed by \_\_\_\_\_ For how long? \_\_\_\_\_  
 Business Phone ( ) \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
**Cell Phone ( ) \_\_\_\_\_ Email Address \_\_\_\_\_**

Would you like to receive appointment reminders via  Text Message ( ) \_\_\_\_\_  Email

## DENTAL INSURANCE COMPANY

Insurance Co. Name \_\_\_\_\_ Insurance Co. Tel. ( ) \_\_\_\_\_  
 Group # \_\_\_\_\_ Policy # \_\_\_\_\_ Local # \_\_\_\_\_  
 Who is the primary person on this policy? \_\_\_\_\_ What is their date of birth? \_\_\_\_\_  
 Primary insured's SSN \_\_\_\_\_ Employer \_\_\_\_\_  
 Do you have Secondary Insurance Policy  Yes  No Secondary Insurance Co. Name \_\_\_\_\_  
 Group # \_\_\_\_\_ Policy # \_\_\_\_\_ Local # \_\_\_\_\_  
 Who is the primary person on this policy? \_\_\_\_\_ What is their date of birth? \_\_\_\_\_  
 Primary insured's SSN \_\_\_\_\_ Employer \_\_\_\_\_

## AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to the doctors at SmileZone, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_