WINDSOR PEDIATRIC DENTISTRY

JILL SHONKA, DDS, PC

FINANCIAL AGREEMENT

Thank you for choosing Windsor Pediatric Dentistry to provide your child's dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask.

DENTAL INSURANCE: As a courtesy, we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:
• You must provide us with an insurance card and all the information necessary to verify your child's coverage and file your claim.
• Although we may estimate your insurance benefits, but we are not responsible for its accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is your responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. Please contact your insurance company with any questions you may have.
• All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one insurance company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

PATIENTS WITHOUT INSURANCE COVERAGE: A discount will be applied at check out when treatment is rendered. A written estimate of fees will be provided for future treatment and payment is expected at each visit for services rendered.

PAYMENT POLICY
• We accept cash, debit cards, Visa, MasterCard and Discover.
• By law your insurance company is required to pay each claim within 30 days. After dental insurance has paid its portion, a statement for the remaining balance will be sent to your mailing address on record. In order to avoid finance charges payment is expected within 30 days of the statement date unless other arrangements have been made.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 30 days of the monthly billing date. A late charge of 1.5% of the unpaid balance will be assessed each month until paid. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

SEDATION: When scheduling an oral sedation, I understand that most insurance does not cover this charge. A sedation fee of $150 is due in full, along with all estimated dental co-payments on the day of service. This fee is not discounted for any reason.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for the full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A $25.00 charge is applied when a check is returned by the bank.

OVERDUE BALANCE: An account with an unpaid balance past 90 days will be sent to a collection agency. Collection fees of approximately 40%, are added to the account when it is turned over to an agency.

FEE FOR MISSED APPOINTMENT IF 24-HOUR NOTICE NOT GIVEN: To reschedule or cancel an appointment, you must notify us at least twenty-four (24) hours in advance to avoid a missed appointment fee of up to $50. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

CONSENT & AUTHORIZATION: I authorize dental treatment on my child and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Windsor Pediatric Dentistry. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:
Name____________________________________Signature__________________________________
Child's Name______________________Relationship to child ____ Date_____________________
Are you the person legally responsible for this child? Yes ______ No _______