CHILDREN'S DENTAL CARE
PEDIATRIC DENTISTRY & ORTHODONTICS

OUR OFFICE POLICY

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

*Any portion not covered by insurance will be due at the time of service. We accept cash, checks, Visa and Mastercard. Any co payments not made at the time of service will be subject to a $25.00 billing fee. There will be a $35.00 charge for all returned checks. All balances older than 30 days will be subject to a $7.00 rebilling fee after the 3rd statement has been sent out and no activity on the account. **A $50.00 charge will be applied for appointments cancelled without 24 hours advance notice.** ***For those families with DSHS/Medicaid, we will be unable to reschedule appointments that are cancelled without a 24 hour advance notice.***

We will gladly discuss your proposed treatment and answer any questions relating to insurance and finances. You must realize, however, that:

1. Your insurance is a contract between you, your employer and insurance company. We are not a party to the contract. We require that you bring your current copy of your insurance card to each appointment.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

3. **The parent that accompanies the patient to all dental visits is considered financially responsible for the account.** Our office policy requires that all children need to be accompanied by an adult at all times in case of an emergency.

   If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I have reviewed the following policy and I agree to be responsible for all dental services not covered by my dental plan, unless the dental practice has a contractual aggreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any claims.

Child's Name_____

Guardian Signature _____ **Date** _____

Kent Office □ 24837 104th Ave SE Suite 200 □ 253-850-1234 □ Fax: 253-850-8393
Bonney Lake Office □ 18008 State Route 410 E Suite B □ 253-826-5000 □ Fax: 253-826-5007

www.childrensdentalcare.com