Financial Agreement

Parent Name: _____

Thank you for choosing Howell Pediatric Dentistry as your child's dental care provider. Our office is committed to providing the best possible care. It is required that you read and sign our financial agreement prior to the start of treatment.

PAYMENT: Payment is due at the time of service. We accept cash, checks, Visa, MasterCard, Discover, American Express, and Care Credit. Checks that are returned to our office from your financial institution are subject to a **$35.00** returned check fee. The fee covers the processing fees that are charged to our office. If partial dentures, space maintainers, occlusal or mouth guards are to be fabricated by a dental laboratory, a **50%** deposit is required at the time of the first impression. The remaining balance is due at the time of cementation or insertion.

MINOR PATIENTS: Minors will not be seen in our office without a parent or guardian present. The parent that accompanies the minor child/children to the appointment is responsible for any payment due. **In the case of divorce, regardless of decree, the parent who brings the child and has signed the financial agreement is responsible for payment.**

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we accept assignment of benefits and your insurance company has not paid on your account in full within 60 days, the balance will be transferred to your account. It is your responsibility to verify with your insurance the benefits that are covered. **Any fees or services not covered by your insurance is 100% your responsibility.** Most insurance companies will downgrade composite (white) fillings to amalgam (silver). Our office does not provide amalgams. Nitrous (Happy) Gas, may not be covered by your insurance. Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. All insurance co-pays and deductibles must be paid at the time of service. We also realize that temporary financial situations may effect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

SEDATION DENTISTRY: Our office provides IV sedation services with a highly trained Pediatric Anesthesiologist. A **$250** deposit is required at the time the appointment is scheduled, and will be applied towards your total co-payment. A separate fee will be charged by our Pediatric Dental Anesthesiologist, and is due at the time of service.

CANCELLATION POLICY: Please be aware that our office requires 24 hours notice for a cancelled appointment. There will be a **$50** cancellation fee if appointment is missed or cancelled in less than 24 hours.

I have read the above financial agreement and any questions have been answered. I understand and agree to this financial agreement. By signing below, I acknowledge that I understand and agree to this financial agreement.

Patient Name (s): _____

Print Name: _____

Signature: _____ Date: _____

Signature of Staff: _____