smile garden
pediatric dentistry

# Financial Consent for Services

## Today's Date:

**Payment: Payment is expected in full for each appointment as services are rendered.**

**Payment options are:**

- Cash
- Check
- Credit Card (MasterCard, Visa)
- Care Credit (special financing on approved credit offering no interest plans)

**Dental Insurance:** Your insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered", "denied", or "over UCR". We will file your primary dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusion, and provisions determined by your insurance company. You agree to be responsible for payment of all services rendered on behalf of yourself and/or your dependents. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will file a pre-determination or preauthorization for recommended treatment when it is requested by you. Note that any insurance predeterminations or insurance estimates are only an estimate. By signing this form, you authorize Smile Garden Pediatric Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to yourself or your child/children to third-party payers and/or other health practitioners.

**Missed Appointment Fee:** A missed appointment is failing to show up for an appointment or changing an appointment with less than 24 hours' notice. A $50 fee will be assessed for each missed appointment. This fee must be paid before new appointments are scheduled. Patients with three missed appointments will be asked to transfer their records to another dental practice.

**Appointment Confirmations:** We reserve the right to reschedule and fill any appointment spot that is unconfirmed by 12:00pm (noon) two business days prior to the scheduled appointment.

**Emergency/After Hours Appointment:** If your child is seen for an emergency visit after our regular business hours, an "after hours" fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time services are rendered.

**Finance Charge:** A finance charge will be added to your account for any balance over $50.00 that is unpaid within thirty (30) days of the date of the service. The finance charge will be computed at the rate of 1 percent (1%) of the unpaid balance per month.

**Returned Checks:** A $35.00 fee will be assessed for any checks returned by the bank and personal checks will no longer be an accepted form of payment.

**Monthly Statement:** If you have an unpaid balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the account, the added finance charge fee, and any payments and credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment. We cannot send statements to any other person.

FLIP OVER

**Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to collections, you agree to pay all collection fees, attorney's fees in the amount of 33.33%, and all cost associated with going to court to collect the debt owed to Smile Garden Pediatric Dentistry.

**Divorce:** In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

This is an agreement between Smile Garden Pediatric Dentistry and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name for the patient to which charges are made and payments are credited. The words "we," "us", and "our" refer to Smile Garden Pediatric Dentistry and Midlothian Children's Dentistry, LLC.

I understand that any fee estimate listed for dental care can only be extended for a period of six months from the date of patient examination. The signature of a parent or guardian affixed below authorizes the completion of all agreed-upon dental treatment and the use of those methods as appropriate thereto. This consent shall remain in full force and effect until cancellation by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should the named responsible party fail to pay and/or insurance benefit be denied. I have read the above conditions of treatment and agree to their content.

**Patient Name** _____ **Birthdate:** _____

_____

**Signature of Parent or Legal Guardian** **Date** **Relationship to Patient (child)**

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**Signature of Guarantor of payment/responsible party** **Date** **Relationship to Patient (child)**