<u>Financial Agreement</u>

To our valued patients:

In order to keep our fees as low as possible we have implemented the following policies:

- **If the patient <u>does not</u> have dental insurance**, payment in full is expected on the day of service.

- **If the patient <u>does</u> have dental insurance,** the responsible party will pay the patient *<u>estimated</u>* portion, and deductible on the day of service. We file your insurance claim as a courtesy, however, **please be aware, if the insurance does not pay within 60 days, payment in full is expected from the responsible party.** Children's Dentistry of Twin Falls bills to 600 insurance companies. <u>I understand that it is my responsibility to know and understand my benefits</u>. I understand that the fee's quoted are only estimates. I am responsible for anything that my insurance does not cover. I understand that if my child has been referred by another dentist, my insurance may not cover the cost of the exam or x-rays due to plan limitations, and it is my responsibility to pay.

- A $25 cancellation/"no-show" fee will be assessed to your account for appointments cancelled or broken without 24 hours notice.

- Upon examination, the doctor will prepare a treatment plan. The **treatment plan is only an estimate** of the dental care required and should not be construed as a statement of actual charges.

- There will be a **$25 returned check fee** assessed to your account on all returned checks. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination. In addition, there will be late fees, rebilling fees and finance charges added to all accounts over 60 days late. Credit checks will be obtained with **all** financial arrangement's that are not paid on the date of service. Information given may be used to collect a debt.

- The responsible party agrees to pay all attorney fees and court costs associated with collecting payment for services rendered. Collection fees of approximately 50% are added to the account when it is turned over to the agency.

- I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information.

I have read and understand the above policy and agree to abide by this policy.

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Signature of Parent or legal guardian	Relationship to child	Date