Financial Agreement

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

•The parent or guardian who brings the patient to their visit is responsible for payment.

•If the patient does not have dental insurance, payment in full is expected on the day of service.

•If the patient does have dental insurance, the responsible party will pay the patient estimated 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. Young Smiles Children's Dentistry bills to hundreds of insurance companies. I understand that it is my responsibility to know and understand my benefits. 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 $50 fee will be assessed to your account for broken or cancelled appointments without 2 business days notice. A $100 fee will be assessed for short notice cancelations or broken sedation appointments.

•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 $30 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 finance charges of 0.875% (10.5% annually) 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 understands that any unpaid balances may be referred to Cornerstone Credit Services for further collection activity.

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

_____ _____

Signature of Responsible Party Printed Name

_____ _____

Relationship to Child Date

_____

Patient Name(s)