Pediatric Dentistry
OF PROSPECT

502.292.1160 • 12927 W. Highway 42 • Prospect, KY 40059

APPOINTMENT AND CANCELLATION POLICY:

One parent is permitted to remain with each child during treatment. Dr. Danielle will discuss with you the terms and conditions for this privilege. Other guests/siblings must remain in the reception room accompanied by an adult. Pediatric Dentistry of Prospect excels in providing a timely visit for you and your child. We keep an accurate schedule for our busy families to ensure your wait in our office will be brief. We request our patients arrive 10 minutes early for their scheduled appointment. Your appointment will be considered "missed" if you arrive more than 10 minutes late and you may be asked to reschedule. **If you need to cancel or reschedule your appointment, a 48 hour notice is required when illness is not a factor. If you miss your scheduled appointment without giving us the required notice, your child may be placed on our "Day of Only" policy (advance appointments are not given). If two or more missed appointments occur, your child may be dismissed from our practice. OR appointments have a $ 100.00 broken appointment charge.**

I have read and fully understand the above appointment and cancellation policies and accept all provisions.

Patient's Name:_____

Parent's/Guardian's Signature:_____

Date:_____ Relationship:_____

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following financial provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the co-payment and/or deductible, which is the amount not covered by your insurance, prior to any service your child may receive.
- Our insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our office. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to sort out any questions. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and understand the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Pediatric Dentistry of Prospect.

Patient's Name:_____

Parent's / Guardian's Signature:_____

Date:_____ Witness:_____

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance is not received within 60 days from the date of billing/service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims, regardless of whether our office is a provider for your insurance company. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file an insurance claim, you must bring to us a dental insurance proof of insurance to be kept on file.

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Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover.

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Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Any returned checks will be assessed a $25.00 charge. Since your bank must, by law, inform you of a dishonored check, we will expect you to contact us to make arrangements for settling the full amount of the check plus $25.00, within ten (10) days. Late payment charges will be assessed if the matter is not settled by that time.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

I have read and fully understand the above financial policy and accept all provisions.

Patient's Name:_____

Parent's / Guardian's Signature:_____

Date:_____ Witness:_____