



Smiles for the Future Pediatric Dentistry & Orthodontics

FINANCIAL POLICY & DENTAL INSURANCE COVERAGE PRACTICE POLICIES

We participate with some dental plans and we will submit our claims to most insurance companies for you, however **NOT ALL SERVICES MAY BE COVERED BY INSURANCE PLANS.**

- If you do not have any dental insurance coverage, ***payment is expected at the time of service.***
- If you or your child is in need of extensive dental work, we can submit a “pre-determination of benefits” to your insurance company so you will have an insurance **ESTIMATE** of the amount you will be responsible to pay.
- Financial arrangements may be made upon request. However, they must be made prior to the first restorative or orthodontic appointment.
- I understand that I will be responsible to pay, at the time of service, any and all amounts not paid or covered by my dental insurance.
- I realize that such charges will include but may not be limited to amounts incurred from deductibles, co-payments, and amounts not paid by my dental insurance due to yearly/lifetime maximums of my benefits.
- I understand and agree that Smiles for the Future Pediatric Dentistry & Orthodontics does not represent my dental insurance company and that Smiles for the Future Pediatric Dentistry & Orthodontics cannot make ANY representation or warranty that my dental insurance company will cover all or any portion of the dental services provided by Smiles for the Future Pediatric Dentistry & Orthodontics.
- I acknowledge that it is my ultimate and sole responsibility to determine whether a dental service, procedure, or treatment program is covered by my dental insurance, and if covered, the amount of coverage that will be provided and whether my benefits are exhausted or will be exhausted during the service, procedure, or treatment program.
- I also acknowledge and understand that Smiles for the Future Pediatric Dentistry & Orthodontics will not, as a matter of policy, agree to halt any service, procedure, or treatment program solely because my dental insurance benefits have become exhausted.
- I understand that Smiles for the Future Pediatric Dentistry & Orthodontics cannot know at what point in my procedure or treatment my insurance benefits will exhaust.
- A late payment charge of 1½% per month (18% annually) will be applied to all accounts that are unpaid over 60 days. I will be responsible for all collection costs, reasonable attorney fees, and court costs. In the event my account is referred to an attorney or collection agency for collection, I agree to pay for processing or convenience fees if required as a cost of collection of my account. I understand that such fees would only be incurred if I optionally choose to pay the account by credit card or check by phone to the attorney or agency. There is a \$30 returned check fee each time an unpaid check is returned to us.
- I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Smiles for the Future Pediatric Dentistry & Orthodontics and I agree to be responsible for all charges for dental services and materials, not paid by my dental benefit plan.
- I confirm that any statement made by any one at Smiles for the Future Pediatric Dentistry & Orthodontics concerning my dental insurance coverage cannot be relied upon as a guarantee of coverage.

I confirm that no representation has been made to me by any one at Smiles for the Future Pediatric Dentistry & Orthodontics that is contrary in any way to the above notice and disclaimer.

Patient's Name: _____

Parent or legal guardian (print) _____

Parent or legal guardian (signature) _____