ACKNOWLEDGEMENT OF OFFICE POLICIES & FINANCIAL DISCLOSURE

In order to become a patient at CPD, please read and agree to the following office policies & financial disclosures. This will apply to all office visits at this practice.

- **BASIC POLICY:** Payment is due in full at the time the service is provided in our office.
- **PATIENTS WITH INSURANCE:** We bill most insurance carriers as a courtesy for you if proper paperwork is provided to us. Applicable co-payments, co-insurances, deductibles, cost of non-dental treatments, claims unpaid due to lack of referral and/or No show/Late Cancel fees as per office policy are your responsibility. Since your agreement with your insurance carrier is a private one, we do not routinely research why any insurance carrier has not paid, or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
- **CANCELLATION POLICY:** In fairness to other patients and the doctors, we require at least 48 hours notice to cancel appointments. You will be charged a non-refundable $75 fee for missed check up appointments per child; $150 for dental treatment visits per child. Multiple occurrences will result in dismissal from the practice.
- **LATE ARRIVALS:** We strive to see patients at their scheduled appointment time. Therefore, if you are more than 15 minutes late, you will need to reschedule your appointment. You will be charged a non-refundable $50 missed appointment fee.
- **RETURNED CHECK POLICY:** Bounced checks will result in bank penalties. Therefore, there will be $50 service fee for all bounced checks.
- **COLLECTIONS:** Balances including those left unpaid due to incorrect information supplied to the office, incomplete, invalid, or denied card transactions will be considered in default and will be forwarded to a collection agency after 60 days of 1st billing statement without notice. A 35% service fee will be added to all balances forwarded to collections.

CREDIT CARD AUTHORIZATION

Why are we asking you for this information?

To all of our new and established patients:

If you have ever checked into a hotel or rented a car, you know that the first thing you are asked for is a credit card, which we willingly give and which is imprinted and later used to pay your bill. If no credit card is given, they usually require a substantial cash deposit.

This is an advantage to you and the hotel or rental company, since it makes checkout faster, easier, and more efficient.

We have implemented a similar policy. You will be asked for a credit card at the time you check in, and the information will be held securely until your insurance company has paid their portion and notified us of the amount of your share of the claim. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge mailed to you. You will have also received an explanation of dental benefits from your insurance company and will have been made aware that there is a portion of the fee that is your responsibility, so the charge will not come as a surprise to you.

This will be an advantage to you since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly reduce the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of healthcare down.

This will not compromise your ability to dispute a charge or question your insurance company's determination or payment.

Co-pays, co-insurance, and any deductible remain due at the time of your visit.

Healthcare is a personal relationship between a patient and a physician. While we don't believe dental care is just like any other product, practices of insurance companies have made payment for dental care like any other product or service.

We ask your understanding with this policy.

I have read the above and understand my credit card will be charged for any charges, which are the patient's responsibility determined by my insurance.

- **REQUIRED CREDIT CARD INFORMATION:** This **REQUIRED** information is secured in our HIPPA compliant system. If your insurance has paid their portion and notified us of your share, remaining balances will be charged to your card. No Show/Late Cancel fees will also be charged to this account.

I, the undersigned, authorize, Chelsea Pediatric Dentistry to charge outstanding balances and fees to the account. I also agree to office and financial policies.

Patient: ____________________________ **Email address:** _____________________________

Name on credit card: _________________________________ **zip code:** ________________

Card Type: (Visa) (MasterCard) (American Express) (Discover) CVV/CID_______________

Card Number: ____ **Expir.Date**_______________

Signature: ____**Today's Date** ____________

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