

Yarmosky Pediatric Dental Agreement

Thank you for choosing our practice for your child's dental care. We are committed to providing the best quality dental care possible and the best service possible. In order to maintain our goal of excellent dentistry, we must also follow sustainable business practices. With that in mind the following is a statement of our Financial Agreement that we ask you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

FULL PAYMENT OF INSURANCE DEDUCTIBLE AND COPAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AND DISCOVER.

REGARDING INSURANCE

Your dental insurance policy is an agreement between you and your insurance company. Please be aware that some, perhaps all, of the services provided may be non-covered services and therefore are your responsibility. If your insurance company has not paid your claim within 45 days, the balance will automatically be billed to you. You and not your insurance company are responsible for your account. You are expected to pay your estimated portion at the same time of service. Any balance will be billed to you and payment is expected within 30 days. If your insurance company does not pay our bill for any reason, you are responsible for full payment. In the event of an account overpayment, we will refund the difference to you. _____

For your convenience, if you sign below we will complete and submit all necessary claim forms and assign insurance payments directly to our office. I authorize Yarmosky Pediatric Dentistry to submit claim forms for me and my family and authorize direct assignment of benefits. _____

APPOINTMENT INFORMATION

If you cannot keep your scheduled appointment we ask for at least 24 hours notice. A \$25.00 fee will be charged for a first failed appointment and a \$50.00 fee will be charged for a second failed appointment. Any failed appointment on school holidays will result in a \$75.00 charge per appointment.

Two failed appointments will result in discharge from our care. _____

PAST DUE ACCOUNTS

Accounts are considered past due after 30 days. Past due accounts will be charged a re-billing/finance charge of \$5.00 per month. Checks returned by your bank will be subject to a return check fee. Accounts turned over to our collection agency or attorney, and sent to court, will be subject to reasonable attorney's fees and court costs. _____

I have read, initialed, understand and agree to this Practice Agreement

x _____
Parent or Guardian Date