SOUTH GEORGIA
PEDIATRIC DENTISTRY

OFFICE FINANCIAL POLICY

We appreciate your allowing us to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding, we offer these clarifications of payment for services.

- Payment in full by cash, check, or credit card at each appointment as service is rendered is requested. For your convenience, Visa and MasterCard are accepted.
- We will be happy to file your insurance claim on the first visit if we have received all of your insurance information. You will need to be prepared to pay any amount that is determined not payable by your insurance plan, such as deductibles and percentages.
- The parent or guardian who accompanies the child is responsible for payment at time of services unless prior arrangements have been approved.
- To ensure prompt and efficient patient care, we require 24 hours' notice to reschedule or cancel appointments. A $50.00 per child reactivation fee will be assessed in order to reschedule if 24 hours' notice is not given.

We are dedicated to providing the best treatment for our patients and our fees are based on the most appropriate treatment for your child. Please note the following:

1. We must emphasize that as health care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. The amount not covered by your insurance is payable at the time of service, such as deductibles and copayments. However, if we do not receive payment from the company within 40 days after the submission of the claim, you will be expected to pay for all dental services in full within 10 days of notification. In the event of duplicate payment, you will be reimbursed.
3. You are responsible for payment regardless of any insurance company's arbitrary determination of fees. Please be aware that some services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.
4. All charges for services rendered that remain unpaid 30 or more days will be subject to a 1.5% monthly finance charge/late fee (18% annually) or a minimum monthly finance charge/late fee of $25.00, whichever is greater.
5. A charge of $35.00 will be assessed on any returned checks and a charge of 2% of any unpaid balance will be added monthly.
6. Should your account be turned over for collection, you will be responsible for the cost of collections, without limitation, attorney's fees, and court costs.

We will do our best to maximize the insurance benefits that you are eligible to receive and we do appreciate your prompt settlement of any charges that may be incurred during treatment. We look forward to years of close association with you as we work together to maintain your child's oral health.

I have read and understand the Office Financial Policy and agree to abide by its contents.

Parent/Guardian Signature_____ **Date**_____

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