Kids Dental Barn

Financial Agreement

Our Primary goal is to provide the highest quality dental care to infants, children and adolescents.

Payment for treatment is expected at the time of service.

For our families who do not have dental insurance, we do offer a cash discount of 10% when you pay your account in full on the day of service. Please ask if other arrangements are necessary.

If a patient has dental insurance, the responsible party will pay the patients estimated portion and/ or deductible on the day of service. The insurance will be billed as a courtesy. Please be aware, if the insurance company does not pay within 60 days, payment in full is expected from the responsible party. **It is the patient's responsibility to know and understand their insurance benefits.** Fees quoted in our office are estimates only. Please understand that insurance companies pay benefits based on their own fee schedule. It is impossible for us to know every insurance fee schedule and their limitations. We are always happy to submit a pre-authorization per your request if you are unsure of your coverage and limitations.

Some procedures are not covered by insurance companies. The patient's guardian is responsible for anything their insurance does not cover.

Our office staff will not act as mediators in a divorce situation.

Balances from previous treatment must be paid before any additional treatment is performed.

Returned checks will be assessed a $25.00 fee.

Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

Please help us keep our costs thus our fees down by not missing appointments. Patients who "no show" an appointment or cancel with less than 24 hours notices will be assessed a $25.00 fee for each appointment blocked scheduled.

I hereby authorize Kids Dental Barn and all associates to release any and all medical and/ or dental information to the insurance carriers. I herby authorize payment directly to Kids Dental Barn and all associates. I understand that I am financially responsible for any and all changes not covered by this authorization.

I have read and understand the above policies and accept the terms of this agreement.

Name of Child/Children_____

Signature of authorized person_____Date_____

Relationship to patient/s_____