Financial Policy

High Point Pediatric Dentistry is committed to your child's successful dental care. Please understand that payment of your bill for services performed in this office *is part of your child's dental care*. Carefully read our financial policy; we encourage you to ask any questions you have regarding billing and insurance. Also, please visit our web site, www.highpointpediatricdentistry.com for additional information regarding dental insurance.

● **The account/account balance is the responsibility of the legal parent/guardian that brings the child to their first visit and completes required paperwork.** We cannot send billing statements to other persons.

● For those who do not have dental insurance, our office will expect payment on the date of service.

● We accept cash, debit cards, Visa, Mastercard, Discover, and Care Credit. We do not accept personal checks. We do not offer in-house "payment plans."

For those with dental insurance:

● **It is the responsibility of the policy holder to know and understand your dental insurance benefits.** Insurance companies change their policies and Usual and Customary Rates (UCRs) constantly. Our office cannot be expected to know each patient's individual policies, coverage, and limitations.

● Prior to your child's first visit, we recommend you contact your insurance provider to ensure benefits are eligible for reimbursement if you choose an out-of-network provider.

● Notify our office immediately when you have a change in your dental insurance.

● As a courtesy to our patients with insurance, we will:
 -File the PRIMARY insurance for you.
 -Obtain *basic* benefit information.
 -Provide estimates for proposed treatment.

High Point Pediatric Dentistry is NOT in-network with any insurance companies.

● **We do not** file secondary insurance of any type.

● **We do not** obtain information about Usual and Customary Rates (UCRs) for your plan.

● **We do not** retro-file insurance for past visits in this office.

● Any portion known not to be covered by insurance is expected to be paid on the date of service.

● Once insurance is filed and payment is submitted to our office, any remaining balance is your responsibility.

● Some insurance companies will not send payment to providers that are out-of-network. Instead, payment is sent directly to you. For these patients, payment is expected in full on the date of service. Current companies that follow this practice are Blue Cross Blue Shield and Delta Dental and Fee Schedule Plans. Your insurance is still filed, and you can expect reimbursement from the insurance company within 2-4 weeks.

● Persons with an outstanding account balance are sent a statement at thirty days. If the balance remains, we reserve the right to apply an interest rate of eighteen percent (18%) from the date of service.

Over, please →

● For account balances outstanding longer than thirty days with no contact from the responsible party, additional action is possible. This can include, but is not limited to: Cancelling scheduled future appointments until the balance is paid, reporting the responsible party to a collections agency or Small Claims court, and potential dismissal from the practice.

● In order for us to file claims with your insurance company, please provide the following information for the POLICY HOLDER (not your child):

Insurance Company: ___________________________________
Employer: ____
Name: ____
DOB: ____
ID#: ____
Group#: ____

- I authorize the release of any information concerning my child's health care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits.
- I authorize the release of any information concerning my child's health care, advice and treatment to another dentist if needed for my child's treatment.
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.
- I understand that I am financially responsible for payments in full on all accounts.
- By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

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Parent/Legal Guardian's Name Signature Date

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Child's Name