CHILDREN'S DENTAL CENTER

7863 Broadway, Merrillville IN 46410
219 769-6636

FINANCIAL/OFFICE POLICIES

Our staff appreciates your selection of this office to serve your dental needs. We are committed to your treatment being successful.

The following is a statement of our Financial Policy, we request you read and sign it prior to any treatment.

- Unless previous arrangements are made – all accounts are due and payable IN FULL at the time of service.
- After 60 days, a service fee of 1% will be added to each statement for any unpaid balance.
- After 90 days, any account which has not had payment(s) made toward the balance will be considered in default and subject to collection proceedings, including any and/or all costs involved.

For those patients who have been in collection due to default of their account, payment will be due IN FULL at the time of service. No further credit will be extended.

Monthly statements will be sent to keep you aware of any balance on your account. As payments are received, from you or your insurance company, they will be posted directly to your account.

Regarding your insurance, we must have a copy of the insurance card. Your insurance policy is a contract between you and your insurance company – we are not a party to that contract. If your insurance company should not pay, any balance is ultimately your responsibility.

We'll take care of filing with your insurance company and do our best to answer any questions you may have. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Each policy is different, but in general, insurance usually (but not always) covers about 80% of simple treatment and 50% of major treatment. Pre-authorization for any treatment will let you know the approximate amount of your obligation ahead of time. This way, initially, you pay only the estimated percentage of your total bill or that portion not covered by your insurance. You are responsible for payment regardless of any Insurance Company's arbitrary determination.

If your insurance pays you directly, all fees are due IN FULL at the time of your appointment.

For patients without insurance coverage, we ask you pay for services on the day they are rendered (we do accept VISA, MasterCard, and Discover).

It is our intention to fully inform you of the anticipated dental treatment before we begin; however, this is only an estimate.

There is a $27.50 fee for checks not honored by your bank.

All minor patients, under the age of 18, must be accompanied by an adult (18 years of age or older), who must remain on the premises at all times otherwise treatment will be stopped.

The adult or guardian accompanying a minor is responsible for full payment due at the time the services are rendered.

Any request for duplicate records will result in a cost of $10.00 (paid in cash) per record and will be released upon receipt of a signed Patient Records Release Authorization and full payment (paid in cash) of any balance due on the account.

We make every attempt to accommodate our patients. We do make a "courtesy" reminder call for all appointments. We do ask for, at least, 24 hours notice of any appointment that is being canceled. While our office is lenient, if we see repeated canceled and/or failed appointments, with no notice, it is our policy to schedule no more appointments for that family.

I HAVE READ, UNDERSTAND AND AGREE TO THESE FINANCIAL/OFFICE POLICIES.

Signature of Responsible Party	Date	Printed Name of PATIENT