Our Financial Policy

Thank you for choosing All About Kids Dentistry for your child's dental needs. We are committed to providing your child with excellent dental care, while being successful in your child's treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Please understand that this financial policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases. This also allows us to concentrate on what we do best…caring for your child.

Full payment is due at the time of service.
We accept cash, checks, or credit card payments including: Visa, MasterCard, and Discover
For our patients with treatment plan fees over $300.00 a three-month payment plan is available free of finance charges. Total patient obligation will be divided as follows: 50% due at the first treatment visit, with the remaining balance split into two equal payments, due 30 and 60 days after the first treatment visit.
Balance payments will be written at the initiation of treatment and post dated payments for 30 and 60 days shall be collected either in the form of a check or credit card slip.
As a courtesy to our patients, we offer a 5% discount on all treatment plans exceeding $500.00 when paid in full by check or cash.

Insurance: Our office is committed to helping our patients maximize their benefits. We may accept assignment of primary insurance benefits; however, we do require deductibles and patient portion be paid at the time of service. Please become knowledgeable regarding your insurance benefits. Each plan is different and independent of other plans-even within the same company. It is ultimately your responsibility to understand your insurance-what is covers, what it does not include. The payment of your bill is ultimately your responsibility whether you have insurance, or use other means to pay for the services your family receives.

We must have complete and up to date insurance information in order to bill your insurance company on your behalf. We will submit your claims to your primary insurance. Once your insurance company has processed your claim in a timely manner, any amount remaining due is the patient's responsibility and will be billed to you.

Payment is due within 30 days of your statement date.
The quality of insurance policies varies greatly therefore we can estimate your coverage in good faith but can not provide any guaranteed coverage due to the complexities of insurance contracts. I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance. If you do not have insurance, payment in full is due at the time of service.
We do not bill secondary insurance policies. This is your responsibility.

Finance Charges: A finance charge will be billed to any account in which the balance remains unpaid for 60 days without payment arrangements. This monthly fee will equal 18% APR.

Missed Appointments: Once an appointment has been made, please remember this time has been reserved specifically for your child. Ultimately, the proper timing of your child's treatment has a great effect on the final predictable result of your child's health care.
Therefore we strongly urge that you do not change or cancel appointments. We see that patients who fail appointment protocols and delay proper care, be it restorative or preventive visits, require more extensive and expensive treatment. **Be advised that the policy of this office is to charge for a missed appointment unless they are canceled by contacting one of our staff 2 business workdays prior to their appointment.** We have patients on waiting lists and need adequate lead time to schedule them into any earlier times that become available.

Returned checks: If a check is returned NSF, there will be a $25.00 charge and, from that point on, checks will not be accepted.

I, the undersigned, assume financial responsibility as stated above and responsibility for all collection and legal fees if my account becomes past due. I have read, understand, and agree to this Financial Policy.

X____ **Date**____________
Signature of Responsible Party