KINGSEED
FAMILY DENTAL

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bills is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

REGARDING PAYMENT

We accept the following forms of payment: Cash, Check, Visa, MasterCard and CareCredit.

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing manager.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before appointment date or previous arrangements have been made with the doctor and/or billing manager.

Checks that are returned to our office from your financial institution are subject to a $25 returned check fee. This fee covers the processing fees that are charged to our office.

REGARDING MISSED APPOINTMENTS

We understand that situations arise that might keep you from keeping your schedule appointment, if that should occur, please note that we require 48 hour notice for cancellations . A $25 missed appointment fee will be charged for any missed appointment without 48 hours notice. Three missed appointments without the required notice could result in dismissal from our practice.

Initial of Patient or Responsible Party X _____

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to proving the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time serves are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.
All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party: X_____ ____ **Date:** _____