FINANCIAL POLICY

Charges incurred for services rendered by Star Kids Dentistry are the patient's responsibility, regardless of insurance coverage. Assignment will be accepted for all insurance with which our office participates. It is the patient's responsibility to provide this office with accurate insurance information and to notify us of any changes in dental insurance coverage. If you have questions on network status/participation with your insurance, it is **your responsibility** to contact the customer service number on your insurance card.

PATIENT/GUARDIAN RESPONSIBILITY: Your insurance may have a co-insurance and/or deductible amount that **must be paid on the day of your appointment.** If there is treatment planned to be completed, you must pay the estimated cost of treatment **before treatment will be rendered.** If there is a change in treatment plan that results in an increase of cost, the cost must be paid **the day treatment is rendered.** If there is a change in treatment plan that results in a decrease of cost, the difference will be refunded to you as soon as possible.

BILLING: It is the patient/guardian responsibility to know your insurance policy. You are responsible for any rejected claims, non-covered expenses, deductibles, and co-insurance/co-payments. Our statements are sent monthly. Cash, Check, Money Order, Care Credit and all major credit cards are acceptable means in which to pay the balance. If there remains an unpaid balance and we receive no payment or contact from the responsible party despite all our efforts to contact said party, then the account will be turned over to the collection agency. Statements will be mailed out monthly. You will have 60 days to pay your account in full, before accruing a 1.5% interest charge. Balances over 90 days will be turned over to the collection agency. There is a $35.00 fee for all returned checks.

I have chosen to allow Star Kids Dentistry to file my insurance and I do accept full responsibility for this account. I also understand that this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within 60 days of my date of service then I will become responsible for payment at that time.

Print Patient Name:_____ Date:_____

Patient/Guarantor Signature:_____ Relationship to Patient:_____