



Financial Guideline

Every child that comes through our door is guaranteed to be treated with only the best materials and technology available. Our Clinical and Business Teams work closely together to create a positive environment and assist with financial requirements.

Payment for professional services is expected at the time dental treatment is provided. A member of our Business Team will be delighted to discuss our options with you!

Options: For your convenience, we accept cash, personal check, debit cards, VISA, MasterCard, Discover, American Express, and CareCredit.

CareCredit: A convenient alternative to credit cards, cash, or checks, CareCredit is a health care card that is exclusively utilized for dental and medical services. It offers flexible payment options that fit your timetable and budget. For additional information, contact us or visit www.carecredit.com

Financial Responsibility: The parent or guardian bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons.

Divorce/Separation: The party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent or guardian bringing the child and authorizing treatment will be the person responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from them. We will provide you additional copies of receipts if needed.

Insurance: We are happy to file dental claims for our families who have dental insurance! In general, we will file claims to any company that will pay us directly and does not restrict coverage to a list of participating providers. *Filing your insurance is not a guarantee of payment.* Please understand that the parent or guardian has the final responsibility for payment of any services rendered. Dr. Winn recommends treatment based on your child's **NEEDS**, not on what insurance will pay.

Your complete insurance information must be present at the time services are provided and updated as necessary. Most benefits will be verified before your insurance company can be billed.

In the event that your insurance has not paid your account within sixty (60) days, the balance will be transferred to your account. We reserve the right to discontinue or refuse to file a claim.

We are a participating provider with the following companies: **Delta Dental PPO, Delta Dental Premier, and Indiana's Medicaid and Hoosier Healthwise.**

Federal and Illinois Employees: Insurance plans for federal employees make payments directly to the member. Payment in full will be collected on the day that treatment is provided.

Statements: If you have a balance on your account, we will send you a statement in the mail. It will show your previous balance, any new charges, and any payments or credits applied to your account.

Past Due Accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date printed on the statement. *A \$5.00 late fee may be charged on any account that is not paid within fifteen (15) days of the statement date.* If necessary, accounts that are not paid within sixty (60) days will be referred to a collection agency. All reasonable expenses incurred in the collection process will be the account holder's responsibility.

Returned Checks: There is a \$30.00 fee for any checks returned by the bank.

Required Payments: At treatment visits, we collect a percentage of the total cost of treatment, determined by an **ESTIMATION** of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will be reimbursed by a check in the mail or it can be left on your account to pay for future services, whichever you prefer.

Effective Date: Once you have signed this guide, you acknowledge all the terms and conditions contained herein and the agreement will be in full force and effect.

I have read the above policies and understand my obligations with The Kids' Dentist, PC for my child's dental care. I acknowledge that I am responsible for payment of any services not covered by my insurance plan.

Parent/Guardian Signature:

Date:
