Anthem Pediatric Dentistry Financial Policies

Thank you for choosing Anthem Pediatric Dentistry for your child's dental needs. **Please carefully read and initial each statement (1-7) and sign below**. This policy has been put in place to ensure that financial payments due are recovered to allow us to provide quality dental care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies wth you.

1. _____I understand that APD will collect all co-payments at the time of visit. Any deductibles and coinsurance up to the amount equal to payment in full for the visit and planned procedure codes will be billed. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and APD. Any over payment to your account will be refunded after payment and/or remittance has been received from your insurance company.

2. _____I understand that a $25 service fee will be added for a returned check.

3. _____I understand that a ***24 hour*** advanced notice is required to cancel an appointment to avoid a ***$50 fee***.
4. _____I understand that if my account is not paid in full within 90 days of a statement date, a 35%collection agency processing fee will be added to the outstanding balance which will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

5. _____APD will allow 60 days from the date of filling for my insurance company to process or pay a claim. State law allows insurance companies operating in Nevada no more than 60 days to process claims. It is my responsibility to provide my insurance company with any requested information needed to process a claim for service. It is my responsibility to notify APD if there is any change in my insurance coverage, residence, or phone number. **ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS**.

6. _____Divorce: the responsible party is the parent that brings the child to the appointment, independent of what a divorce decree may state. Reimbursement must be made between the divorced parties.

7. _____The fee for nitrous oxide and sedation must be paid at time of scheduling.

8. _____ I understand that during treatment it may be necessary to change or add procedures based on conditions found while working on the teeth. I give permission for Anthem Pediatric Dentistry to make any and all changes, and additions, as necessary.

I have read and agree to all the provisions of the above financial policy. I understand that I an ultimately responsible for all professional fees incurred for professional services performed.

Parent/Guardian Name: _____ _____
Print Signature

Date: _____

ASSIGNMENT OF BENEFIT

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to doctors office.

I hereby assign all dental benefits, to which I am entitled, by private insurance or ay other health plan to: Anthem Pediatric Dentistry. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Name_____ Signature of responsible party_____

Date_____