Kids Dental Experts®
Dental Specialists for Children & Teenagers

## REVIEW OF FINANCIAL POLICY FOR ADULT PATIENTS

**Patient Name:**_____ **Date of Birth:**_____

**Payments:** Fees not covered by insurance and deductibles will be collected at the time of service. Payments are accepted in the form of cash, check, debit, money order, MasterCard, VISA, Discover, American Express, HSA accounts, and CareCredit. A courtesy discount of 5% will be granted to those who have no outstanding balance and are paying in full with cash or check for that day's services. A monthly 1% (12% yearly) or minimum of $2.00 past due fee will be charged on any delinquent account. A $25.00 service fee will be charged to your account if a check is returned nonsufficient funds.

**Responsible Party:** When children turn 18 years of age, parents will be given the option to continue to be responsible for that child's expenses or have the child assume responsibility for their own account.
Please note that we are a pediatric dental office, specializing in children's teeth and oral health. Patients over the age of 18 are encouraged to begin seeking dental care with a general practice dentist that will be able to accommodate oral health care needs into adulthood. Patients will have until they are 21 years of age to continue as a patient while seeking a general practice dentist.
Patients who have received completed orthodontic treatment with Kids Dental Experts® will need to seek any additional orthodontic treatment through an adult orthodontic specialist. At that time, Kids Dental Experts® will no longer be the primary orthodontist for care but will be happy to forward records to a new specialist.

**Failed/Missed Appointments:** Please call with cancellations or to reschedule as soon as possible. A reservation fee may be charged for missed appointments or cancellations with less than 48 hour notice.

**Insurance:** I authorize payment from my dental benefits carrier directly to Kids Dental Experts®. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill of service, and by signing this statement, I agree that I am financially responsible for payment of any remaining amount. Insurance delays or lack of coverage does not exempt me from making full payment within 45 days of services rendered. Any balance not paid within 45 days will be subject to collection proceedings. As a courtesy, the office offers the option of storing my credit, debit, or HSA card information on file so that any remaining balance after insurance settlements can be processed automatically.

**Notice of Privacy Practices:** I have been offered and understand the Privacy Practices. _____
Initial

**I understand and agree to the above and am financially responsible for the patient listed above.**

**Signature:**_____ **Date:**_____

**Print Name:**_____ **Relationship to Patient:**_____

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