



SURF'S UP PEDIATRIC DENTISTRY FINANCIAL POLICY

PATIENT NAME (Please Print): _____

We appreciate the opportunity to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding, we offer these clarifications of methods and policies for payment of services. Payment in full by cash, check or credit/debit card at each appointment is due at the time of service. For your convenience, Visa, MasterCard, Discover, and American Express are accepted. We do not extend long term credit, as we are not a lending agency.

- We will be happy to file your insurance claim starting on your first visit if we have received accurate insurance information. You will need to be prepared to pay any amount that is determined not payable by your insurance company, such as deductibles and co-pay percentages. Please understand that we cannot become involved in prolonged insurance negotiations. If our office has not received payment from your insurance company within 60 days from the date of service, the balance in full becomes your responsibility.
- The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.
- We are dedicated to providing the best treatment for our patients and our fees are based on the most appropriate treatment for your child. Please note the following:
 1. We must emphasize that as health care providers, our relationship is with you, not your insurance company. Your insurance contract is between you, your employer, and the insurance company. We are not a party to that contract. Any amount the insurance does not pay will be your responsibility.
 2. The amount not covered by your insurance is payable at the time of service, such as deductibles and co-payments. However, if we do not receive payment from the insurance company within 60 days after the submission of a claim, you will be expected to pay for all dental services in full within 10 days of notification. In the event of duplicate payment, you will be reimbursed.
 3. You are responsible for payment regardless of any insurance company's arbitrary determination of fees. Please be aware that some services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.
 4. Because it is difficult for us to fill an opening on short notice, all no-show and canceled appointments with less than 24 hour notice will be charged a fee that will need to be paid before the appointment can be rescheduled. These fees are: \$25 for a routine hygiene appointment, \$50 for an operatory appointment, \$100 for an in-office general anesthesia appointment, and \$200 for an out-patient hospital appointment.
 5. Should your account be turned over for collections, you will be responsible for all cost of collections, without limitation, attorney's fees, and court costs and/or filing fees associated with collection. You will agree to pay the remaining balance along with a collection agency commission of 40% of the delinquent balance in the event your account is assigned to a collection agency.

We will do our best to maximize insurance benefits that you are eligible to receive. We also appreciate your prompt settlement of any charges that may be incurred during treatment. We look forward to years of close association with you as we work together to maintain your child's oral health.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters relating to this form. I certify that I understand completely and accurately everything stated above and I hereby agree to abide by the conditions outlined therein.

I have read and understand Surf's Up Pediatric Dentistry's Financial Policy and agree to abide by its contents.

Name _____ Signature _____ Date _____