COASTAL MAINE
Pediatric Dentistry

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Financial Agreement

Please be aware that the parent bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons. Please understand that financial arrangements are made directly with you. For the convenience of our patients, the following outlines your financial agreement with Coastal Maine Pediatric Dentistry:

1. Payment is due in full for each appointment at the time services are rendered. We accept cash, personal checks, MasterCard, Visa, American Express, and Discover. We offer financing through Wells Fargo Healthcare Finance, Simple Pay, and Care Credit. There is a $35 fee for returned checks.

2. In the case of divorce or separation, the parent who brings the child to the appointment is responsible for the payment. If the divorce decree requires the other parent to pay part or all of the treatment costs, it is the responsibility of the parent attending the appointment to collect from the other parent. Our office will not intervene.

3. Dental and Medical Insurance: The type of plan chosen by you and your employer determines your insurance benefits. Your insurance contract is between you and your insurer/employer. As such we have no say in the selection of your insurance company, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. We will assist you in estimating your coverage and will collect your estimated payment responsibility at the time of service. If your insurer's payment differs from our estimate we will either credit your account or invoice you for the difference. You are responsible for any amount not paid by your insurance. Any insurance payment not received within 30 days will be billed to you. I authorize and request that my dental insurance company pay directly to the dentist or dentist's group insurance benefits otherwise payable to me.

4. Pre-Treatment Authorization: Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be your responsibility to determine if you wish to proceed with the treatment before the insurance benefit is determined.

5. Fillings: Our dental material of choice is a white (composite resin) filling. Please be aware that your insurance company may not pay for a composite resin filling at the same level as a silver (amalgam) filling. Any portion not paid by your insurer is your responsibility. In some cases the dentist may recommend placing a silver crown instead of a resin filling.

6. Nitrous Oxide (Laughing Gas)/Oral Sedation: Nitrous Oxide/Oral Sedation is not always covered by dental insurance. Any portion not paid by insurance is your responsibility.

7. Appliances: The entire cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory fees when the appliance is ordered, not when completed. We do offer financing specific to orthodontic appliances.

8. Emergency Treatment: All emergency treatment must be paid in full at the time the service is rendered.

9. Cancellation Policy: We require 24 hours notice if you wish to cancel, 48 hours for siblings booked together on the same day. After your first failed appointment you will be assessed a $35 failed appointment fee, after your second you may be dismissed from the practice. A failed appointment is defined as a cancellation without the above requested notice, or an appointment missed without notice. If you are more than 15 minutes late for your appointment we may be unable to see you at your appointed time.

Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that your insurance coverage is a relationship between you, the insured/patient, and your insurance company. Past due accounts are subject to a monthly service charge of up to 1.5% that will be assessed to any unpaid past-due balance each month and will be turned over to an outside agency for collection. You agree to pay any and all attorney fees associated with the collection of monies due.

By signing I acknowledge that I have read and understand my financial obligation.

Completed by (print): _____ Relationship to patient: _____

Signature _____ **Date** _____/_____/_____