

# Financial Agreement

## *Ann Arbor Pediatric Dentistry*

### **Payment Responsibilities:**

- Payment is due at the time of service, including estimated insurance deductibles and copayments.
- We accept cash, personal checks, VISA, MC, Discover and American Express.
- We charge a \$26.00 fee for unpaid checks returned from the bank.
- We charge a **\$35.00 fee** for missed appointments and appointments cancelled with *less than 1 business days' notice*.
- Divorce Situations: The adult who brings the child to their appointment is responsible for any payment due at the time of service. Please inform us, no later than the date of service, of any CHILD CUSTODY arrangements that may affect billing or insurance claims submission.

### **Insurance Policy:**

Our dentists recommend preventative services and treatment based on what we believe is best for your child. We do NOT and CANNOT recommend treatment based on your insurance coverage. If you have any questions regarding the proposed treatment or cost, please ask and we will provide a complete explanation.

As a service to our patients, we offer insurance claim submission. Please understand that we can only **ESTIMATE** your insurance coverage. By submitting your insurance claims directly for you, we handle one step in the process. Deductibles or copayments are to be paid at the time of service. Please be aware that dental insurance companies rarely cover 100% of dental fees. We are committed to helping you achieve the maximum benefit to which you are entitled.

I hereby authorize and direct payment of dental benefits, otherwise payable to me, directly to the billing dentist.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian Name (please print)

\_\_\_\_\_  
Parent or Legal Guardian Signature

Affordability: If you have a true financial hardship, which will prevent your child from receiving the recommended care, please let us know. We can discuss your payment plan options.