

## Grin & Company Pediatric Dentistry

### Financial Policy

Payment for services, including deductibles and co-pays, are due at the time of service. If you do not have dental insurance, we require full payment at the time services are rendered. Payments may be made using cash, check, or credit cards. Any arrangements for third-party financing must be made before starting treatment.

Grin & Company accepts most dental benefit plans. Please keep in mind that your insurance policy is a contract between you, your employer, and the insurance company. As a courtesy, we will do our best to estimate insurance coverage and patient portions due. This is only an estimate of what is reported to us by your dental carrier. This is not a guarantee of payment of the service. After treatment, we are happy to submit the claims necessary to see that you receive your benefits. You are ultimately responsible for all charges. **If the insurance company does not pay the full amount anticipated, you are responsible for the difference.** Payment is expected within 10 days after the statement date.

In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that dental insurance is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit.

**For dependents from the age of 18 to 23**, the parent that was responsible for the charges prior to turning 18 will continue to be responsible until they notify the practice that they are no longer responsible AND the dependent signs their own office policy acknowledging that they are now responsible for their own charges going forward. Any charges incurred during this transition will always be the responsibility of the initial responsible party.

Dr. Sarah Boyles will diagnose and recommend treatment based on your child's dental health needs, not on insurance coverage.

Checks that are returned to our office from your financial institution are subject to a \$25 returned check fee. This fee covers the processing fees that are charged to our office.

Please indicate your understanding and acceptance of these financial policies by signing below. This form must be signed in order to proceed with your scheduled appointment.

Patient's name \_\_\_\_\_ Date \_\_\_\_\_

Parent's name (print) \_\_\_\_\_ Date \_\_\_\_\_

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_