PEDIATRIC DENTISTRY OF NEWNAN

Dr. Kim J Mathews

Appointment Policy/Financial Policy

We appreciate you choosing Pediatric Dentistry of Newnan, LLC for your child's dental health needs. Our office reserves a specific time for your child according to their treatment needs and cooperation level. We make every effort to see your child at their appointed time. Inadvertent delays, such as emergencies and unforeseen patient treatment problems may arise causing schedule changes. If your child's appointment time is delayed, please accept our apology. Your patience is very much appreciated under these circumstances.

Please arrive 5 to 10 minutes prior to your child's scheduled appointment. This will allow time to complete any necessary paperwork. If you arrive 15 minutes beyond your appointment time, you may be asked to reschedule for the next available appointment time. Younger children and children requiring complex dental treatment usually perform better when they are well rested and alert; therefore, morning appointments are highly recommended. We will be happy to provide your child with a signed school excuse to satisfy school attendance requirements. As a courtesy, we will attempt to contact you to confirm your child's appointment; however, we ask that you assume responsibility for your child's appointed time. If you need to reschedule an appointment, we ask that you provide our office with 24hour notice so that we may extend the appointment time to another patient. There will be a $25 fee charged to your account for all appointments that are canceled and/or broken within less that 24 hrs. Multiple broken appointments (3 or more) without prior cancellation notice may be subject to dismissal from the practice. If at any time you have questions concerning our appointment policy please ask our office staff for assistance.

*** Please familiarize yourself with the following information. Fees incurred are due in full when services are rendered.***

1. For your convenience we accept Cash, Check, Money Orders, Bank Issued Checks, MasterCard, Visa, and Discover. We are a participating provider for Care Credit, which offers comfortable finance options. Please ask our administrative staff for more information.
2. There is a $35 fee for any checks returned by the bank.
3. You are entirely responsible for the balance of all treatment. We will file your primary dental insurance **as a courtesy. Please understand that your policy is a contract between you and your insurance company. RECOMMENDED TREATMENT IS BASED ON NECESSITY AND NOT WHAT YOUR POLICY COVERS. Hence, the insurance company is responsible to the patient and the patient is responsible to us.**
4. To avoid disappointment, we suggest you contact your insurance company to make certain your dental coverage assumptions are correct. Most insurance companies only pay a portion of the dental investment. You agree to pay any portion of the charges not covered by insurance. We will attempt to estimate any out of pocket expenses prior to your visit to our office. Please be prepared for any deductible, copay, or other expenses at the time of service. We will file a predetermination for recommended treatment when it is requested by you. If your insurance company requires a referral, you are responsible for obtaining it. If, for any reason, your insurance company does not respond with financial payment within 45 days post treatment, the balance is due and payable in full immediately by the financially responsible parent/legal guardian.
5. The parent/legal guardian who brings the child to the office is responsible for payment in full. We do not get involved in custody and/or financial disputes which may or may not involve court orders. We will not bill a third party.
6. If your child is seen for an emergency visit after our regular business hours, an “after hours” fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time of service.
7. If your account balance becomes 90 day past due, we will take necessary steps to collect this debt and you agree to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred. Collection fees will equal 50% of the amount turned over for collection.

I have read and understand the policies of Pediatric Dentistry of Newnan.

_____	_____
Parent/Legal Guardian Name (Printed)	Parent/Legal Guardian Signature
_____	_____
Date	Relationship to Patient

(Over)