# Trussville Pediatric Dentistry

## FINANCIAL POLICY

We are pleased that you have chosen us for your child's dental care. We want establish a long and pleasant relationship with you and your child. We understand that the filing of dental insurance can be a very complicated and time-consuming task. We want to assist you in any way possible to receive the maximum benefit from your insurance. We need your understanding and cooperation in the following guidelines regarding the filing of your insurance claims and payment.

1. We are contracted as preferred provider for the following insurance companies:
   - **Blue Cross Blue Shield of Alabama**
   - **Delta Dental Premier**
   - **Guardian**
   - **Medicaid**
   - **Metlife**
   - **Southland**

All applicable deductibles, co-payments, and co-insurance amounts are due at the time services are rendered. We accept cash, check, Mastercard and Visa. Some dental services may not be covered by your contract. In the event a given procedure is not covered, payment for these services is your responsibility. **A 24 hour notice is required for cancellation of an appointment. If you miss two appointments without a 24 hour cancellation notice, you will be charged a $35.00 fee per hour scheduled, if you miss a third appointment with the practice you may be dismissed as a patient.** You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone numbers associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using a pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

**If your insurance is not with one of the above companies—Please see the following paragraph**

2. **If your insurance is through a company with whom we are not contracted:**
   *Please check your contract to determine if you are required to see a preferred provider for that company, understand that if you choose to see a non-preferred provider, your insurance may not pay the full amount or pay at all.
   *Your insurance is a contract between you and your insurance company. Our office is not a party to that contract.
3. While the filing of insurance claims is a courtesy that we gladly extend to you:
   *ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED. In the event the balance is unpaid and turned over for collections, any and all fees, such as collections fees, attorney fees or court cost, will be added to your account. These charges are your responsibility.

In order to facilitate accurate prompt reimbursement, we request that you give us complete and correct information. If you have any questions regarding your insurance coverage or our financial policy, please do not hesitate to ask. We are happy to help you and appreciate your cooperation. Again, we are very thankful you have chosen us to be your child's dental care provider.

By my signature, I acknowledge that the above insurance policy has been thoroughly explained to me and I understand and agree to comply with said policy..

Signature of Responsibility Party_____ Date_____

Patient's Name_____