



Financial Guideline

*Thank you for choosing us as your child's dental health provider. We are committed to the successful treatment of your child. **Please understand that payment of your bill is considered part of your child's treatment.** The following is a statement of our Financial Guideline that we require you to read, agree to and sign prior to any treatment.*

Payment is due at the time services are rendered. This means that once treatment has occurred, payment must be issued before exiting the office. As a courtesy to you we will be happy to assist you in the filing of your dental insurance. Please note we do not file secondary insurance. If we are unable to verify insurance coverage you will be expected to pay in full for your child's visit **on the day of service**. If your insurance has not paid within 30 days of your child's visit you are responsible for the portion not paid by your insurance. If your child's insurance pays more than expected we will quickly send you a refund. It is also your responsibility to inform us of any changes in your child's insurance coverage.

We will accept cash, money orders, Visa, Mastercard, American Express, Discover and CareCredit as forms of payment.

All accounts with an outstanding balance after 60 days of treatment being rendered will be assessed a non-refundable finance charge of 1.5%.

We sincerely appreciate your trust and look forward to helping Grow your child's Grin.

I have read, understand and agree to the provisions of this Financial Guideline.

Signature: _____ Date: _____
(Signature of person Financially Responsible for Account)