

THE GREENSBORO CENTER FOR PEDIATRIC DENTISTRY

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FINANCIAL POLICY

We are doing everything possible to hold down the cost of dental care. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED WITHIN 30-90 DAYS OF THE TIME OF SERVICE

Payment in full is required on all balances of \$250 within 30 days from the time services are rendered. Balances over \$250 are to be paid within 90 days of time of services unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. The Greensboro Center for Pediatric Dentistry accepts cash, personal check, VISA, MasterCard, and Discover. There is a service charge for returned checks of \$25.00.

INSURANCE:

We bill all dental insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. Please contact your insurance company if they have not made payment within 45 days of the date of service. We will make all efforts to follow up on all claims if all insurance information is correct.

***Delta Dental sends payments for services rendered directly to the insured. All patients with Delta Dental are required to pay the full amount at the time services are rendered. As a courtesy, we will bill your insurance so that you will be reimbursed promptly.**

If you need assistance or have questions, please contact the Billing Coordinator between 8:00 a.m. and 4:30 p.m., Monday through Thursday at 292-0411.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Greensboro Center for Pediatric Dentistry's Financial Policy. I agree to assign insurance benefits to the Greensboro Center for Pediatric Dentistry whenever necessary. I also agree that if it become necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured and/or legal guardian:

Date: _____

Child/Children Name: _____