Newburyport P.C. PEDIATRIC DENTISTRY
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FINANCIAL POLICY

Our office is committed to providing you with the highest quality dental care using only the best material and technology available. Our clinical and administrative teams work closely together to provide a positive environment for visits to our office and assistance with financial requirements. A member of our administrative Team will be happy to discuss our options with you.

Payment Due: The full balance of treatment is due at the time services are rendered. Payment plans are not available from our office. For your convenience we accept cash, check, debit card, CareCredit®, Master Card, Visa, and Discover.

Financial Responsibility: The parent or guardian bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons.

Statements: If you have a balance on your account, we will send you a statement in the mail. It will show your previous balance, any new charges, and any payments or credits applied to your account.

Past Due Accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date printed on the statement. *A 1.5% late fee may be charged on any account that is not paid within fifteen (15) days of the statement date*. If necessary, accounts that are not paid within 60 days may be referred to a collection agency. All reasonable expenses incurred in the collection process will be the account holder's responsibility.

Insurance: We are happy to file dental claims for our families who have dental insurance. In general, we will file claims to any company that will pay us directly and does not restrict coverage to a list of participating providers. *Filing your insurance is not a guarantee of payment*. Please understand that the parent or guardian has the final responsibility for payment of any services rendered. Our doctors recommend treatment based on your child's needs, not on what insurance will pay. We will do everything possible to maximize your benefits.

- Your complete insurance information/card must be presented at the time services are provided and updated as necessary. Most benefits will be verified before your insurance company can be billed however; it is ultimately your responsibility to understand your insurance benefits.
- In the event that your insurance has not paid your account within 60 days, the balance may be transferred to your account. We reserve the right to discontinue or refuse to file a claim.
- We are a participating provider with the following companies: **Altus Dental, Blue Cross Blue Shield of MA, Delta Dental of MA, and MassHealth.**

Required Payments: At dental visits, we collect a percentage of the total cost of treatment, determined by an **ESTIMATION** of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will be reimbursed by check in the mail at your request.

Divorce/Separation: The party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent or guardian bringing the child and authorizing treatment will be the person responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from them. We will provide you additional copies of receipts if needed. We do not split bills.

Returned Checks: There is a $25.00 fee for any checks returned by the bank.

CareCredit®: A convenient alternative to credit cards, cash or checks, CareCredit® is a health care card that is exclusively utilized for dental and medical services. They offer flexible payment options that fit your timetable and budget. For additional information, contact us or visit www.carecredit.com.

I have read the above policies and understand my obligations with Newburyport Pediatric Dentistry for my child's dental care. I affirm that my signature represents my agreement to all of the terms and conditions mentioned above.

Parent/Legal Guardian's Name (Print) **Relationship to Child**

Signature **Date**