FINANCIAL AGREEMENT

Thank you for choosing Simi Childrens Dental Group to provide your child's dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask.

PAYMENT POLICY

We accept cash, personal checks, debit cards, Visa, MasterCard, Discover and American Express, and Care Credit. Although we do not offer direct payment options; we do offer a 5% discount off of all treatment plans in excess of $500 that are pre-paid and in full. And all payments are always due at the time services are rendered.

MISSED APPOINTMENT FEE

There is a $75.00 charge per missed appointment. You must call to reschedule or cancel any appointments at least twenty-four (24) hours in advance to avoid this fee. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

ORAL SEDATION

A **non-refundable** sedation fee of $173 is due in full at the time of scheduling and is applied towards the cost of treatment. When scheduling an oral sedation, I understand that most insurance does not cover this charge. This fee is not discounted for any reason. All other treatment fees, deductibles and co-payments are due on the day service is rendered. I understand that if I do not keep this appointment and/or cancel the appointment without a minimum of 24 hours notice, the deposit is forfeited and will not be refunded.

IV SEDATION

A **non-refundable** sedation fee of $500 is due in full at the time of scheduling and is applied towards the sedation fee. When scheduling IV sedation, I understand that insurance may not cover this charge. The sedation fee is due in full; along with all estimated dental deductibles and co-payments on the day service is rendered. This fee is not discounted and is not refundable for any reason. All payments for IV sedation will be payable directly to the anesthesiologist on the day of the appointment. Payment for treatment and/or copays and deductibles will be payable to our office. The parent or guardian accompanying the minor is responsible for payment in full, unless prior arrangements for payment have been made.

DENTAL INSURANCE

As a courtesy, we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and/or all the information necessary to verify your child's coverage to file the claim.
- Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is your responsibility.
- Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment.
- Not all the services we provide are covered benefits. Benefits differ from one insurance company to another.
- Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.
- Please contact your insurance company with any questions you may have.

PATIENTS WITH NO INSURANCE

A written estimate of fees will be provided for treatment once a complete examination, radiographs and diagnosis has been completed upon your child. Our office proudly offers a membership plan which offers an amazing amount of savings for our un-insured and under-insured patients. Inquire with any staff member for further details.

MINOR PATIENTS
The parent or guardian accompanying the minor is responsible for the full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment. ***This office will not attempt to collect payment from a parent that is not present in the office at that visit.***

CONSENT & AUTHORIZATION: I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse and/or my employer and the dentist is not a party to this contract. Therefore, I acknowledge that ultimately I am fully responsible for the payment of any and all sums owed to the dentist for the services rendered on my child / children. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance information and any changes thereto.

All returned checks will be subject to a $25.00 returned check fee. Any account balances that remain unpaid for 30 days from the date balance is past due shall accrue interest at the rate of eighteen percent (18%) per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney’s fees incurred in connection therewith. I consent to the dentist’s use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Your Name (Printed): ____

Signature____ ***Date:*** ______________________

Your relationship to child / children: ____

Child’s Name____ DOB: ______________________

Child’s Name____ DOB: ______________________

Child’s Name____ DOB: ______________________

Child’s Name____ DOB: ______________________

Are you the person legally responsible for this child? Yes ______ No _______