

Financial Agreement

Hanover Pediatric Dentistry
8203 Center Path Lane, Suite A
Mechanicsville, VA 23116

804-746-7382 (office)
804-746-3025 (fax)

Payment: Payment is expected in full for each appointment as services are rendered. Fifty percent (50%) of the expected patient portion of the treatment cost is necessary to schedule an appointment. The remainder is due in full on the day of service. Payment options are:

- Cash
- Check
- Credit Card (MasterCard, Visa, American Express)
- Care Credit (special financing on approved credit offering no interest plans)

Dental Insurance: Insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered", "denied", or "over UCR". We will file your primary dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusion, and provisions determined by your insurance company. You agree to pay any portion of the charges not covered by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will file a pre-determination for recommended treatment when it is requested by you.

Missed Appointments: A missed appointment is defined as a cancellation no show, or reschedule of an appointment with less than 24 hours notice. Our office requires 24 hours notification if you are unable to keep your scheduled appointment. If less than 24 hours notice is given a \$50 fee will be charged to your account. Patients with three missed appointments may be asked to transfer their records to another practice. If a sedation or general anesthesia appointment is missed, the patient will be inactivated and dismissed from the practice. If any first time appointment is missed, the patient will not be seen by the practice.

Emergency/After Hours Appointment: If your child is seen for an emergency visit after our regular business hours, an "after hours" fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time of service.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the account, collections charge, if any and any payments or credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment; we cannot send statements to other persons.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections cost which are incurred.

Collections Charge: A collections charge will be added to your account for any balance that is unpaid within (60) days of the date of the service. The COLLECTIONS CHARGE will be eighty-six dollars (\$86) plus any court costs.

Returned Checks: There is a fee (\$35.00) for any checks returned by the bank. If there is a returned check, payment by check is no longer allowed.

Divorce: In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. 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 the other parent.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

This is an agreement between Hanover Pediatric Dentistry and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name for your child to which charges are made and payments are credited. The words "we," "us", and "our" refer to Hanover Pediatric Dentistry.

Patients Name

Parent/Legal Guardian/Responsible Party(printed)

Parent/Legal Guardian/Responsible Party (signature)