South Shore Pediatric Dentistry and Orthodontics

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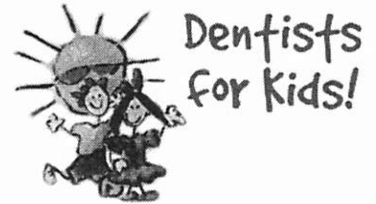

Authorizations and Financial Policy

Appointments - In order to provide each child with the individual care and attention that they deserve, we ask that you arrive on time for your scheduled dental appointments. We work hard to see each patient at their scheduled appointment time. Due to the nature of our practice, we understand that accidents and emergencies happen. We ask for your patience if we are delayed in seeing your child due to treating another child on an emergency basis.

Late Arrivals - Arriving late may cause the appointment to be rescheduled at a later date and time to accommodate other patients on the schedule who arrived on time. We will do our best to accommodate you and your child into our schedule.

Cancellations - We kindly ask you to inform us at least twenty-four (24) hours notice if you need to change your scheduled dental appointment. Less than 24 hours notice, or not showing up for an appointment is considered a missed appointment. A **fee may be charged** for each missed appointment.

Payment - Our mission is to make the cost of optimal care as easy and manageable as possible. It is our policy that ***payments be made at the time of treatment***. Payments can be made by:

- Cash/Personal Check, Debit Card
- Visa, MasterCard, American Express, Discover
- CareCredit (subject to credit approval)

Insurance - Our office will strive to make dental care for your child as affordable as possible. We file your claims with your insurance company to maximize your benefit and directly bill them for reimbursement for your child's dental treatment. Please keep in mind that:

- Dental insurance benefits do not work the same way as medical insurance benefits.
- Every insurance plan is different.
- Co-payments are due at the time of treatment.
- You are responsible for your deductible every year.
- Claims are made at the time of treatment and if not paid in 120 days, you are responsible for your treatment fees and collection of benefits directly from your insurance carrier.
- Benefits cannot be carried over from year to year. If the maximum benefit is reached for the year, you will be responsible for the remaining treatment provided that calendar year.

I, ______________________________, hereby authorize my insurance benefits to be paid directly to South Shore Pediatric Dentistry. I understand that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature ______________________________ Date ______________________

Patient Name (Please print) ______________________________ Relationship ______________________