Smiles4Kids
DENTISTRY FOR CHILDREN

Financial Agreement

To our valued patients:

In order to keep our fees as low as possible we have implemented the following polices:

- The parent or guardian who brings the patient to their visit is responsible for payment of any incurred charges on the date of service.

- If my child is covered under the Idaho Smiles program (Medicaid) I agree that any uncovered services that are rendered or ineligibility on the date of service would be my financial responsibility.

- If the patient does have dental insurance, the responsible party will pay the patient estimated portion, deductible, and/or any other balance not covered by the insurance on the day of service. As a courtesy to you, we will process your insurance forms and claims. **However, your insurance policy is an agreement you have with your insurance carrier. If you have questions regarding payments from your insurance company, we recommend that you call your insurance provider directly for the most accurate and speedy answer.** Regardless of insurance, I agree the balance will be paid in full within 60 days of treatment, unless previous arrangements have been made. Should my account exceed 90 days, one percent (1%) interest per month, twelve percent (12%) per year will be charged. Smiles 4 Kids bills to hundreds of insurance companies. I understand that it is my responsibility to know and understand my benefits and limitations including, but not limited to: bitewings and fluoride. I understand that the fees quoted are only estimates. I understand that if my child has been referred by another dentist, my insurance may not cover the cost of exam or x-rays due to plan limitations, and it is my responsibility to pay.

- If the patient does not have dental insurance, payment in full is expected on the date of service, unless previous arrangements have been made. If financial arrangements are made, I agree the balance will be paid in full within 90 days of treatment. Should my account exceed 90 days, one percent (1%) interest per month, twelve percent (12%) per year will be charged.

- All information given may be used to collect a debt. The responsible party agrees to pay all attorney fees and court costs associated with collecting payment for services rendered. Collection fees totaling approximately 50% are added to the account when it is turned over to a collection agency.

- Upon examination, the doctor will prepare a treatment plan. The treatment plan is only an estimate of the dental care required and should not be construed as a statement of actual charges. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination.

- There will be a $35 returned check fee assessed to your account on all returned checks.

- I authorize the dentist or his designees to release financially identifiable information, treatment descriptions, and information either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information.

_____ _____

Signature of Responsible Party Printed Name

_____ _____

Relationship to Child Date

_____

Patients Name(s)