Westport Pediatric Dentistry
305 Post Road East, Westport, CT 06880
(Tel) 203-226-5500 (Fax) 203-226-5501

Please complete in blue ink.

Westport Pediatric Dentistry Financial Policy

Our office is committed to your child's dental treatment. Please understand that payment of your bill is considered part of treatment. We ask that you read and sign this agreement prior to treatment.

PAYMENTS

- We accept cash, checks, Visa, MasterCard, AMEX and Discover.
- If you don't have dental insurance, full payment is due at the time of service.
- If you have dental insurance:
    - Insurance deductibles and co-payments are due in full at time of service.
    - After your insurance pays or denies your claim, we will charge your credit card on file the remaining balance on your account and e-mail you a receipt same-day.
- In the event of divorce or separation, the person who signs this financial policy for the child will be financially responsible for treatment costs.
- There is a $25 service charge for all returned checks.

INSURANCE INFORMATION

We are not "in-network" with any dental insurance companies. However, as a courtesy to our patients, we submit claims to all dental insurance companies with "PPO" coverage. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment when you request our assistance in doing so. You are responsible for any balance on your account after 45 days, whether your insurance company has paid or not. We will be glad to send a refund to you once your insurance pays us. We would need all of your insurance information prior to the visit. We will do our best to verify coverage and inform you of the estimated balance due. In the event we cannot verify your insurance coverage with your insurance company, we would require full payment and a statement of services will be provided to you so that you can be directly reimbursed by your insurance carrier. ***Due to the many different insurance policies and frequent changes in coverage, it is impossible for us to know them all. You must also take responsibility to familiarize yourself with your dental coverage*****.** We recommend that you contact your insurance carrier directly to understand your benefits. Please know your insurance policy is a contract between you and the carrier. We are not a party to that contract, therefore it is important for you to be involved to help assure timely payments on your account.

USUAL AND CUSTOMARY RATES

Your dental insurance benefits are not determined by our office, but by your dental insurance policy. Dental insurance can sometime reimburse at a lower rate than the dentist's actual fee. Benefit breakdowns that insurance companies provide state a percentage of coverage (not actual dollar amounts) based on arbitrary usual and customary rates (UCR) determined by your insurance company which can be very misleading to both the patient and the provider. We charge usual and customary rate for Fairfield County. You are responsible for the difference between your policy's coverage allowance and our office fees.

MISSED APPOINTMENTS

If appointments are cancelled / rescheduled within 48-hours or if you no-show for an appointment, a fee of $65.00 *per appointment* will be applied to your account to recoup staff costs for the time we have reserved for you. We reserve the right to terminate our professional relationship if you fail to keep three appointments. Please help us serve you better by keeping your scheduled appointments.

FINANCE CHARGES & THIRD-PARTY COLLECTION AGENCY

Accounts not paid within 30 days of the date we send you an invoice are subject to an 18% monthly finance charge. If your account is not paid within 90 days, your account will be sent to a third-party collection agency and you will be responsible for the fee charged by the collection agency for costs of collections in addition to the amount of the bill.

I understand and agree to this financial policy.

____
Patient Name(s)

___________________ ____________
Parent/Guardian Signature Date

CREDIT CARD AUTHORIZATION

We require this section to be completed for future payments:

Cardholder Name:_____________________________

Card Number: ________________________________

Exp. Date:_______

Security Code: (3 digits for MC, Visa, Discover) ______ (4 digits for AMEX)______

Card Type (circle one): VISA MasterCard AMEX Discover

Health Savings Account (HSA)/ Flexible Savings Account (FSA) Card: ▫ Yes ▫ No

E-mail address (for the receipt):_________________________________

I,____________________________________, authorize Westport Pediatric Dentistry charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature________________________________ Date:_______________