Financial Policy

Thank you for choosing **Kids Dentist** as your child's oral health care provider. We are committed to your child's treatment being successful. The following is a statement of our **Financial Policy,** which we require that you read and sign prior to any treatment. Please understand this financial policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases. This also allows us to concentrate on what we do best…taking care of your child.

Full payment is due at the time of service.

We accept cash, checks, and all major credit cards.

Interest free financing is available with credit approval for treatment totaling over $200.00 through *Care Credit*. Please inquire at the front desk for more information.

Insurance:
We may accept assignment of insurance benefits; however, we do require deductibles and co-payments to be paid at the time of service. The balance is your responsibility until paid in full. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract nor are we responsible for procedures that are not covered for any reason. You are responsible for any balance left after your insurance has paid. We must have **complete** and up- to-date insurance information in order to bill your insurance company on your behalf. In the event that your insurance company has not paid their portion within 60 days, the balance will be billed to you.

Billing Charges:
A billing charge will be applied to any account which has a balance 45 days past due. This monthly fee will equal 18% APR or a minimum of $5.00.

Collection Fees:
Accounts that remain unpaid after 45 days may be turned over to our internal collection department. When an account becomes 90 days past due, collection action may be taken outside of **Kids Dentist**. These collection efforts will incur collection fees that total 50% of the account balance and any additional interest, collection and/or legal fees charged by the outside collection service.

Missed Appointments:
Unless cancelled at least **24 hours** in advance, there will be a **$65.00** broken appointment charge. Please help us to serve you and other patients more efficiently by keeping scheduled appointments.

Returned Checks:
If a check is returned unpaid, there will be a $35.00 charge and checks will no longer be accepted.

I, the undersigned, *assume financial responsibility* as stated above and responsibility for all collection and legal fees if my account becomes past due. I have read, understand, and agree to this Financial Policy.

Child's Name_____ Date of Birth _____

X _____ _____
Signature of Responsible Party Date

X_____
Print Name of Responsible Party

Kids Dentist Grayslake, IL 60030