OCONOMOWOC pediatric dentistry

Insurance / Financial Agreement

Full payment or Insurance Co-payment and Co-insurance (your estimated portion) is due at every appointment

Understanding Dental Insurance

- Our relationship is with our patients. Our responsibility is to provide patients with treatment that best meets their needs.
- The quality of service and fees for treatment are based on our knowledge and expertise and are not dictated by insurance coverage.
- Dental insurance is a benefit designed to help with a portion of the cost of dental care.
- An insurance policy is a contract between the patient, their employer, and the insurance company. The percentage of reimbursement and benefits vary depending on the plan purchased by the employer and the limitations of that plan.
- An insurance company may only reimburse a portion of the rates they determine are usual, customary, and reasonable (UCR). The UCR is the amount an insurance carrier will pay for a specific service based on the level of coverage negotiated by the employer.
- 100% coverage on an insurance policy may not cover 100% of the dental office fees due to the UCR set by the insurance company.
- Insurance policies and contracts differ considerably in benefits offered and services allowed. It is your responsibility to know the details of the dental plan.
- Insurance companies reimburse based on the information received once a claim has been submitted for payment. Benefits are based on plan limitations and eligibility at the time services are rendered. Coverage is not definite until the claim has been received and processed for payment.
- We do our best to calculate an accurate estimation of the amount due at each appointment. Any balance on an account after insurance payment has been received will be billed. The patient is responsible for all charges regardless of insurance coverage.
- Any insurance information provided by our office is an estimation of benefits, not a guarantee of coverage or payment.
- Our office will file insurance claims for our patients and follow up on their behalf.
- We are in network with Delta Dental Premier.

I have read the understanding dental insurance information listed above.

I agree to be responsible for all charges for dental services not paid by my dental plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the billing dentist or dental entity.
I agree that a copy of this signature is as valid as the original.

Signature of parent or legal guardian____ Date____/____/____
*Typed name above constitutes my digital signature

Financial Agreement

Payment Options: Several payment options are available to assist you in fulfilling your financial obligations;

We accept: Cash, Check, VISA, MasterCard, or Discover

We also accept CareCredit Credit Card, offered thru GE Capital Retail Bank, a third party lending institution.
For more information about CareCredit, check online at CareCredit.com.

Broken/Cancelled Appointments
Since our time with our patients is very precious to us and lost time is irretrievable, we reserve the right to charge for broken/cancelled appointments when we have not been notified at least 24 hours in advance. Our fee for broken/cancelled appointments is $50. This fee is subject to change without notification. Our desire is never to find it necessary to make this charge. Please keep your appointment, we are waiting for you.

Additional Information
The policy of this office is to charge 1% monthly interest (12% annual percentage rate) that will be applied to all accounts 60 days or more past due. Any account 90 days past due may be turned over to a collection agency. Fees incurred to collect payment will be billed to and payable by the responsible party on the account.

We charge $40 for returned checks. This charge is subject to change without notification.

Financial Consent

I understand that I am responsible for full payment of all treatment performed at Oconomowoc Pediatric Dentistry.

I understand and agree to the information provided in this Financial Agreement.

Patient Name____ Date of Birth ____/____/____

Signature of Parent or Legal Guardian____Date____/____/____
*Typed name above constitutes my digital signature