White Oak Pediatric Dentistry

Financial Policy

Thank you for choosing White Oak Pediatric Dentistry. Please carefully review and sign our Financial Policy below. **If any questions arise, please do not hesitate to speak with our front office staff**.

1. Patients with dental insurance must provide accurate and complete information **PRIOR** to appointment time. **Failure to do so will result in delays with the claims submission process**.
2. Our office is **OUT-OF-NETWORK** with all insurance carriers. "Out-of-Network" simply means that if there is a difference between **OUR** fee and the **ALLOWABLE FEE** set by the insurance plan, that the responsible party will be responsible for the difference.
3. As a courtesy, we will file insurance benefits through the patient's **Primary** insurance plan. We **DO NOT** file claims through secondary insurance plans but we are happy to provide the necessary forms that will be required to do so. The primary insurance plan is defined as the plan that came into effect first. If both primary and secondary plans became effective on the same date, it is based on the Subscriber's date of births.
4. Our relationship is with our patients, not with the dental insurance company. The dental insurance contract is between the subscriber, employer, and insurance carrier. The percentage covered by the insurance carrier is always based on the carrier's MAXIMUM **ALLOWABLE FEE,** not our professional fees. Our office will commit to maximizing our patient's insurance benefits, based on the information provided to us by the company. **OUR OFFICE DOES NOT DETERMINE DENTAL BENEFITS.**
5. Prior to completing restorative dental treatment, a treatment plan will be provided. This treatment plan will include our total fee along with our **ESTIMATED** out of pocket cost. Some insurance carriers do not reimburse the office directly. **If the insurance plan pays the subscriber directly, the responsible party on the account will be required to remit payment for the services rendered.**
6. Any amount not covered by the insurance company is payable at the time of services. These fees include the patient portion, deductibles, co-payments, and certain procedures that are not covered by the insurance policy.

7. We accept cash and all major credit cards. We **DO NOT** accept personal checks.
8. **We cannot accept responsibility for negotiating a disputed claim. We allow a maximum of 45 days for the insurance company to clear account balance. If the insurance company does not remit payment to our office within 45 days of the date of service, we expect payment in full from the responsible party on the account.**
9. Any account over 90 days is subject to collections, unless previous arrangements have been made. Collection fees will equal 50% the amount turned over to collections. **The responsible party on the account is responsible for payment once an account has been turned over to collections.**
10. If a patient is brought to an appointment by a family member/guardian other than the responsible party, the patient portion will still be due on the date of service.
11. Full balance on the account is owed by the responsible party. Our office does not negotiate among guardians on the patient's account.
12. As a **courtesy**, we do our best to remind you of your child's appointment time. We realize that unexpected things may happen, however, our office requires a 48 hour notice to cancel or change appointments, so we can ensure we have availability for other patients. A missed appointment fee of $50 will be applied to the account if there is less than a 48 hour cancellation notice. **In the event that you fail to keep your child's appointment without a 48 hour notice, we reserve the right to discontinue treatment for your child(ren).**
13. Prior to scheduling an operative visit, a $50 deposit will be required. In the event that a 48 hour cancellation or rescheduling notice is not provided, this deposit will cover the cost of the missed appointment fee.

I have read and accepted the above Financial Policy. I understand, acknowledge, and agree that I am fully responsible for the total payment of all procedures performed, including treatment that is not a benefit of any dental insurance plan my child(ren) may have.

Printed name of Parent/Guardian (RESPONSIBLE PARTY): _____
Signature of Parent/Guardian (RESPONSIBLE PARTY): _____
Date: _____