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PEDIATRIC DENTISTRY AND ORTHODONTICS

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Geoffrey M. Hersch, D.D.S., APC | Pediatric Dentistry
Leslie Butler, D.D.S., Inc. | Pediatric Dentistry
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FINANCIAL POLICY

We are committed to providing your children with the best possible dental care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees or your financial responsibility.

PAYMENT

Payment in full, co-payments, patient shares, deductibles and payment for retail products are due at the time of service. We accept cash, checks, Visa, and MasterCard. Returned checks are charged a fee of $25.00. A $50.00 charge will be added to accounts that are sent to collections.

PPO INSURANCE

We will, as a courtesy, bill your insurance company for you. However, if the balance on your account becomes over 60 days past due, it will be your responsibility to follow up with your insurance company and pay the balance due on your account.

INSURANCE PAYMENTS

Insurance reimbursements vary depending on the benefits of each specific policy. We will estimate your patient portion due at the time of services. However, this is only an estimate and you are ultimately responsible for the entire balance in the event that your insurance company fails to pay the entire balance after 60 days.

CANCELLATION POLICY

24-hour notice must be given for all cancelled appointments. If no notification is given, missed or cancelled appointments may be charged a $25.00 cancellation fee. If three appointments are missed, or rescheduled without 24 hours notice, we will not be able to schedule any additional appointments in our office. We will, at that time, recommend you see dentist. Your reserved appointment time is very valuable.

MINORS

A parent or guardian must accompany all minors. The parent or guardian that accompanies the child is responsible for payment at the time of service.

**Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, usual and customary charges, etc. other than to supply factual information as necessary. You are responsible for timely payment of your account. **

I have read and understand the above information.
Patient Name:_____

Responsible Party Signature:_____ Date:_____