FINANCIAL and APPOINTMENT POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. ***It is our policy to make definite financial arrangements with you before any treatment starts.*** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. **Payment for services is due at the time services are rendered**. We accept cash, checks, and credit cards (VISA, MasterCard, AMEX, and Discover) and Care Credit.

2. You must provide the office with a dental insurance card with the proper mailing address of the insurance company, or provide a dental claim form, which is provided by the employer. If one of these documents is not available and presented to our office two business days prior to the appointment, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.

3. **Lonestar Kid's Dentistry is considered an out of network provider with all PPO insurances. We are unable to file any HMO and DMO claims.** If you have insurance, we will gladly process your claim. **We request that you pay your ESTIMATED portion when services are rendered. Any amount not covered by insurance or difference in estimated portion is the patient's responsibility. The office will accept assignment for only the primary insurance coverage**, secondary insurance coverage must be paid to the patient. We will gladly provide you with a receipt for secondary insurance filing.

4. **The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.**

5. There will be a charge of **$75.00 per child for NO SHOW appointments, cancellations or reschedules with less than 24 hours notice.** We reserve time in our schedule especially for your child and in consideration of others, we request **at least 24 hours notice prior to cancellation or reschedule of appointments.** We do understand that there are circumstances that may prevent you from keeping your child's appointment, however with providing us as much notice as possible we may be able to contact another family who would like that appointment time. Afternoon appointments fill quickly, and cancelling with less than 24 hours' notice does not allow us enough time to schedule another patient in need of treatment. Patients that are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment.

6. **Patients may have their appointments rescheduled if they are more than 10 minutes late for their appointment time in consideration for other patients.**

7. **Appointments cancelled with less than 24 hours notice on a school holiday, or an after-school time will NOT be rescheduled on another school holiday, or after school appointment time, as they are our most popular appointments.**

8. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.

9. There will be a $30.00 service charge for all returned checks.

10. **The office cannot carry balances longer than 90 days;** regardless if the insurance payment is still pending. A $5.00 monthly re-billing charge will be added to your account if it is not paid within 60 days, regardless of balance amount. After 90 days, we will inform you of the delinquent account by letter and if no action is taken to clear the account, this office will be required to employ a collection service to collect payment. The responsible party agrees to pay all reasonable, related collection fees.

11. For emergency visits we require payment in full at the time of the appointment.

AUTHORIZATION

1. I authorize Dr. Rubin, Dr. Sentelle and staff to release any information concerning my case to my insurance company.
2. I have read & accept the above Financial and Appointment Policy, understand it & agree to the terms set forth regarding payment.

______________________________________ ____________________

Signature of Parent or Responsible Party Date