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|  | Southern Pediatric Dentistry P.A. 1515 N. Fant Street Anderson, SC 29621 Office: 864-844-9393 Fax: 864-844-9395[www.southernpediatricdentistry.com](http://www.southernpediatricdentistry.com)  |

**FINANCIAL POLICY**

**FULL PAYMENT IS DUE AT TIME OF SERVICE**

Our office gladly accepts Personal Checks, Cash, Visa, and MasterCard. A fee of $50 will be applied to overdrawn accounts.

**For Patients with Insurance**

As a courtesy to our patients with insurance, we will file your dental &/or medical claims for services rendered. You are responsible for paying any deductible and copayment at the time of service. Our office staff makes every effort to be as accurate as possible when collecting these amounts; however, your insurance plan may not cover as much as we estimate. Any amount not paid by insurance is your responsibility. We will be happy to file a pre-determination to the insurance company so we can get a more accurate estimate of what they should pay, but it is still not a guarantee of their payment. Once we receive payment from the insurance company, you will be required to pay the balance due upon receipt of your statement. The balance due for services provided is the patient’s responsibility, even if the insurance company pays nothing. If you have overpaid your portion, you will receive a refund. Refund checks are processed biweekly. Note: We do NOT back date insurance.

**Delinquent Accounts**

We reserve and will exercise the right to report any account 90 days past due to a Collections
Agency. All expenses incurred as a result will be the patient’s responsibility, as permitted by Law.

**Cancellations and Missed Appointments**

Appointments are valuable blocks of time and when an appointment is broken or cancelled with short notice, we are often prevented from filling that time and helping other patients. Please give at least 24 hour notice when you will not be able to make your scheduled appointment. This will allow us time to help other patients and helps keep costs down. There will be a charge for appointments broken or cancelled with less than the required 24-hour notice and you may be prohibited from rescheduling. Additionally, if you are more than 15 minutes late for an appointment, you may have to be rescheduled.

**All Patients Please Sign**

By signing below, I certify I have read, understand, and agree to this financial policy.

**Patient Signature**:

**Guardian/ Parent Signature**: