EDUARDO CORREA, D.D.S, INC.- FINANCIAL AGREEMENT

Primary Dental Insurance:_____
ID#_____
Employer:_____
Name of Subscriber:_____
Subscriber DOB:_____
Subscriber SSN:_____

Secondary Dental Insurance:_____
ID#:_____
Employer:_____
Name of Subscriber:_____
Subscriber DOB:_____
Subscriber SSN:_____

Dental Insurance

- We are dedicated to providing all our patients with the finest treatment available and base our treatment recommendations on what will be best for your child, not what your insurance company does/does not pay.
- Our relationship is with you and your child, not your dental insurance company. Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- As a courtesy, we will verify your insurance eligibility prior to your child's appointment. However, **our office does not determine your dental benefits.** Knowledge of benefits, benefit amounts, co-pays, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility.
- We will gladly file your claims and accept assignment of dental benefits, however, you are responsible for our fees and not what your insurance company allows.
- Based on the information your insurance company provides our office, we can only estimate your insurance benefits, we are not responsible for their accuracy and cannot guarantee payment from your insurance. All charges not paid by your insurance company are your responsibility, regardless of the reason for non-payment. Not all the services we provide are covered benefits. Benefits differ from one company to another.
- **Fees for non-covered services, deductibles, and co-payments, are due at the time services are rendered.**

PAYMENT POLICY

- We offer the following methods of payment: Cash, MasterCard, Visa, Discover, American Express + Care Credit.
- After your dental insurance has paid its portion, a statement will be mailed to you for the remaining balance. Payment is expected within 30 days of the statement date.
- If the insurance company does not pay in full within 30 days of the claim date, you assume responsibility to pay the full balance within 2 weeks of the statement date.

RETURNED CHECKS

- A check that is returned for non-sufficient funds (NSF) will be assessed a fee of $45.
- Unfortunately, if a check has been returned for non-sufficient funds, we will no longer be able to accept checks from that party. All payments received from that point forward will need to be made by cash, debit, or credit.

OVERDUE BALANCE

- An account with a past due balance of 90 days, will be sent to collections. At that time, you will be responsible for any and all costs incurred in the collection of your debt: the unpaid balance, attorney fees, court fees, and any other fees associated with the collection of your debt.

***I have read, understand, and agree to the policies that have been outlined. I authorize dental treatment on my child and I take full responsibility for the account I have with Eduardo Correa, DDS Pediatric Dentistry. I also authorize this office to bill my insurance for all agreed upon dental treatment and agree to pay all related professional fees.**

Child's Name:_____ DOB:_____
Parent/Guardian Name:_____ Date:_____
Signature:_____

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BROKEN/MISSED APPOINTMENT POLICY

- Your child's scheduled appointment time is reserved specifically for them. We try to remind parents by telephone, email, or text prior to their appointment time. However, please do not depend on this courtesy.
- We have a strict **48 hour cancellation policy**. If a cancellation is unavoidable, please call the office at least 48 hours in advance. We understand that illnesses or other unexpected emergencies make it necessary to cancel an appointment with less than 24 hours notice. If this should happen, please contact our office immediately and we will do our best to accommodate you. Broken/missed appointments with less than 48 hours notice will be assessed a fee of $50 for each broken/missed appointment.

LATE ARRIVAL

- Our office has a **10 minute grace period** from the time of the reserved appointment. Should you arrive more than 10 minutes late for your child's appointment, you may be asked to reschedule for the next available appointment time.

TREATMENT APPOINTMENTS

- Treatment appointments **MUST** be confirmed at least 48 hours prior to the appointment time. If our office does not receive a confirmation, we reserve the right to schedule another treatment patient who may have urgent treatment needs at that time.
- If your child's treatment appointment is broken without a 48 hour notice, we reserve the right to collect a $50 deposit to reschedule the appointment.

APPOINTMENT DELAYS

- We make every effort to see all patients on time for their scheduled appointments. Due to unforeseen circumstances, there may be times when our schedule is delayed in order to accommodate an injured child, an emergency, or a special needs patient. We thank you in advance for your understanding in this matter.

Cell Phone:

❑ I consent to the dental practice using my cell phone number to (choose one or both) ❑ call or ❑ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) _____ _____(initial)

***I have read, understand, and agree to the above Broken/Missed Appointment policies that have been outlined.**

Child's Name:_____ Date: _____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____