Adventure Dental
Pediatric Dentistry and Orthodontics

Financial Policies, Arrangements and Conditions

Welcome to our practice! We are pleased that you have selected our office for your child's dental care and we value the confidence you have expressed in choosing Adventure Dental. We understand that parents are concerned not only with the quality of their children's dental care, but also with the costs of professional services. Therefore, we have outlined below the financial policies of this office.

- Payment is expected the day service is rendered. This includes co-payments and deductibles.
- If you carry dental insurance, please present your current insurance card the day of your child's appointment.
- As there are many different insurance plans available, we recommend that you contact your employer or insurance representative to obtain details regarding your benefits and eligibility.
- You will be responsible for any charges denied by your insurance plan.
- Delinquent accounts may be subject to a monthly finance charge.
- Your account is subject to a $50.00 charge per half hour for cancellations without a 48 hour notification. Please remember, once an appointment has been made this time has been reserved especially for your child.
- There will be $25.00 fee for returned checks due to insufficient funds.

I certify that my child (or children) is covered under _____ insurance and I assign appropriate insurance benefits directly to Adventure Dental.

I understand that I am responsible for any remaining balance not covered by my insurance, and hereby authorize Adventure Dental to release all information necessary to secure payment for dental services rendered. I authorize the use of this signature on all my insurance submissions whether electronic or manual.

The parent/guardian, signed below agrees to be fully responsible for the total payments of procedures performed in this office. In cases of shared custody and/or divorced/separated parents, the parent/guardian presenting the child for treatment is responsible for the charges incurred.

Please be aware that your insurance may or may not cover the fluoride or x-rays recommended.

I authorize the recommended fluoride treatment for my child/children even though my insurance may not cover it. I understand that I am responsible for all charges incurred if my insurance does not cover the procedure. ☐ Yes ☐ No

I authorize the recommended x-rays for my child/children even though my insurance may not cover it. I understand that I am responsible for all charges incurred if my insurance does not cover the procedure. ☐ Yes ☐ No

I have read and fully understand the financial policy of this office and have received a copy

Parent/Guardian Signature Print Name Date