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 our 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 information/card the day of your child's appointment. We do not bill insurance claims retroactively.
- You will be responsible for notifying us for any changes to your insurance. Please acknowledge that your insurance *will not* notify us if there are any changes to your plan. Please inform us of any changes to your insurance 24 hours prior to any appointments.
- 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. However, we do take into consideration that there are some unforeseen circumstances that may arise.
- There will be $25.00 fee for returned checks, and ACH transactions due to insufficient funds.

I understand that I am responsible for any remaining balance not covered by insurance, and hereby authorize Adventure Dental to release all information necessary to secure payment for dental services rendered. I hereby give Adventure dental the assignment of appropriate insurance benefits, and authorize the use of this signature on all 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 some services provided, e.g., fluoride, x-rays, etc... Please understand that estimates provided are not a guarantee of coverage. We highly recommend that you understand your insurance benefits, and contact your insurance carrier if you have any questions regarding coverage.

I understand that I am responsible for all charges incurred. I have read and fully understand the financial policy of this office, and have been offered a copy.

Parent/Guardian Signature Print Name Date