**Vernon Pediatric Dentistry**

**Maya Vernon DDS**

**Financial Policy**

Thank you for choosing our practice for your child’s dental care. It is our practice goal to provide exceptional pediatric dentistry for your child along with excellent customer service. The following is a statement of our Financial Policy, Please read and sign prior to any treatment.

**YOUR FULL PAYMENT IS DUE AT TIME OF SERVICE.** Payments can be made as: Cash, Check, Visa, MasterCard or Discover.

**Insurance**

If you have dental insurance, **full payment** of your insurance **deductible** and **estimated responsibility** is **due at the time of service**.

Your dental insurance policy is an agreement between you and your insurance company. Please be aware that some and perhaps all of the services provided may be non-covered services, and therefore are your responsibility. **You are responsible for your account, not your insurance company.**

**You are required to pay your estimated portion at the time of service.**  Any subsequent balances will be billed to you and payment is **due within 30 days**. We will, on your behalf, bill and follow up on claims to your insurance. It is your responsibility to advise the office immediately of any insurance changes, balances on claims rejected due to terminated insurance will revert to full office fees and will be your responsibility. All other non-covered services under an active in-network policy will be billed to you at the contracted in-network insurance rates. In the event of any patient overpayment, we will refund the difference directly to you via a check. **Our office does not do a “split bill” for divorced or separated parents, the parent bringing the patient to the appointment is the responsible party and must pay all fees due at time of service. The parent must collect any balances due to them from the other party; our office does not get involved in domestic financial issues or agreements.**

**Appointment Information**

We make a special effort to provide you and your family with quality dental care, including reserving a special time for you and your family to receive care. Should you have to cancel your appointment please let us know 48 hours in advance.

Unless canceled 48 hours in advance, you may be charged for a missed appointment at the rate of a normal office visit. **All failed appointments will be charged a $50.00 failed appointment fee that is non-refundable.**

**Past Due Accounts**

Accounts are considered past due **after 30 days**. Past due accounts will be charged a rebilling /finance charge of **$5.00 per month**. Checks returned by your bank will be subject to a return check fee.

**I have read, and understand and agree to this Financial Policy.**

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**Parent or Guardian Signature Date**