FORT WORTH
pediatric
DENTISTRY

BRUCE H. WEINER, D.D.S. | JANELL I. PLOCHECK, D.D.S. | NATHAN G. WEST, D.M.D.
Diplomates of the American Board of Pediatric Dentistry

Financial Policy

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our financial policy. If you have any questions, please do not hesitate to ask.

1. **Payment for services is due at the time services are rendered.** We accept cash, checks and credit cards (Visa, Mastercard, Discover, American Express and Care Credit).
2. **New patient emergency visits must be paid in full at the time of the appointment.** As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for reimbursement or you may assign the payment to our office and we will file the primary insurance for you. Secondary insurance will be filed only if the correct information is provided at the time of service.
3. You must provide the office with correct **dental** insurance information at the time of the service to include the mailing address, phone and group number. If insurance coverage cannot be verified, you will be responsible for the payment of all fees and we will provide you with a claim for you to submit for reimbursement.
4. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and estimated co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. Any remaining balances will be billed to you after a claim is paid.**
5. Blue Cross Blue Shield and many Delta Dental plans do not allow payment assignment to non-providers. We will file your BCBS and Delta insurance, however, **you will be required to pay in full at the time of service** if your plan is determined to be a non-assignment plan. BCBS and Delta will send payment directly to you.
6. Past due accounts will be notified via statement notes. If the account remains unpaid, we will be required to employ a collection service to collect payment. There is a **$5.00 per month late fee for accounts over 60 days.** The responsible party agrees to pay all related collection fees. **There is a $35.00 service charge for all returned checks.**
7. Our office will make every reasonable effort to obtain payment from your insurance company. If the claim remains unpaid after 120 days, you will be responsible for the remaining balance. Any additional insurance appeals will become your responsibility. We will be happy to provide you with any necessary forms and receipts.
8. **The parent or guardian who brings the child for an initial visit is the responsible party. This parent or guardian is required to pay for services rendered regardless of what a divorce decree may state.**

AUTHORIZATION

1. I authorize the Doctors and staff of Fort Worth Pediatric Dentistry to release any information concerning my case to my insurance company.
2. I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

Date: _____

Patient Name(s) (Please Print): _____

Signature of Responsible Party: _____

Print name of Responsible Party: _____