madison pediatric dentistry

financial policy

Thank you for choosing us to provide your child's dental care! We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

Dental Insurance: Our office is dedicated to providing all of our patients with the finest treatment available and base our treatment recommendations on what will be best for your child and not what your insurance company does or does not pay. Please review the following in regards to your dental insurance coverage:

- We must emphasize that as a dental care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between you and your insurance company.
- As a courtesy, we will file your insurance claims. Any amount determined not to be covered by your insurance is due at the time services are rendered. These fees may include deductibles, co-payments, and procedures not covered by your insurance policies.
- If insurance does not pay my claim within 60 days, payment is expected from the responsible party within two weeks.

PAYMENT POLICY:

- We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, Discover and CareCredit.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance.
- We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees and payment is expected at each visit for services rendered. We are happy to provide discounts for services paid in full up front. Payment arrangements may also be offered prior to treatment.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. We will look to the adult accompanying a minor for all services rendered to minor patients. Our doctor and staff will discuss with you the cost of treatment and each of the available payment plan options so that you are able to make the best choice for you and your child. We take our reputation for being a generous office very seriously and we will work with you to make this process as easy as possible. We are so excited to be treating your child!

CONSENT AND AUTHORIZATION: I authorize dental treatment on my child and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Madison Pediatric Dentistry. Without any reservations, I agree to abide by the policies outlined herein.

parent/guardian signature:_____ date:_____

please print name: _____

Consent for treatment: The information that I have given is correct and completed to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I am the LEGAL GUARDIAN of the patient. I authorize Dr. Andersen/authorized associates/staff to perform the necessary dental procedures including, but not limited to the use of Nitrous Oxide (laughing gas), Lidocaine (Novacaine-like), and any necessary xrays on my child.

PROCEDURES WILL ALWAYS BE DISCLOSED WITH YOU PRIOR TO ANY DENTAL TREATMENT.

parent/guardian signature:_____ date:_____

please print name: _____

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