FINANCIAL POLICY

At our office, we plan to work together to achieve one common goal and that is for our kids to grow up feeling confident about their smiles. We promise to properly communicate all that is needed to obtain that goal, including our financial policy.

Payment in full for office visits and treatment is expected at the time service is rendered. Patients with dental insurance must provide our office with accurate dental insurance information in advance.

INSURANCE

We can file most major PPO dental insurances. In the event we are not a provider for your dental insurance, we will file the claims as an out-of-network provider for you. This means that at the time of service, you are required to pay the difference of what the insurance company is estimating not to pay. This includes deductibles, co-payments and any service performed that is not covered by your policy. If any balance is remaining after insurance has paid, a statement will be sent to you requesting that you pay the remaining balance. In some instances, some insurance companies will not reimburse our office. This will require you to be responsible for the full cost of each visit at the time service is provided.

In special instances we may accept assignment of benefits; however, you must understand that:

Your dental benefits plan is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not the benefits company.

All charges are your responsibility whether your benefits company pays or declines to pay. Not all services are covered benefits in all contracts.

Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

If your benefits company does not make any payment within 30 days of submission of the claim, we ask that you contact the company.

If there is no payment within 45 days of claims submission, the entire balance is then your responsibility and the payment is expected by you, the insured.

Returned checks and balances older than 30 days may be subject to an additional collection fee and interest charges of 1 ½ perfect a month.

By signing this form, I am authorizing assignment of benefits and payment from my child's dental insurance directly to Dr. Justin Bloom, D.M.D. I also am authorizing Dr. Justin Bloom to furnish my insurance company with any and all information that may be contained in my child's medical and dental records that relates to procedures performed in the office of Dr. Justin Bloom.

Any questions you have may be directed to our office and we will be happy to assist you! We are looking forward to beginning a wonderful relationship with you and your child.

I have read and understand the above financial policy set forth by Smiles in Bloom Pediatric Dentistry and agree to be held responsible for the terms and conditions mentioned above.

Signature of parent/ legal guardian_____ Date_____

Print Name_____ Relationship to patient_____

Patient's Name _____