STATEN ISLAND PEDIATRIC DENTISTRY

195 Bridgetown Street, Staten Island, NY (718)-761-7316

OUR FINANCIAL POLICY

Thank you for choosing us as your child's dentists. We are committed to providing your child with optimum dental care. Please understand that payment of your bill is considered part of your child's dental treatment. The following is a statement of our financial policy which we require you to read and sign prior to any dental treatment.

Payment is expected at the time of service:

We accept cash, checks and Visa, MasterCard, American Express and Discover credit cards. If you have the need to carry your financial commitment over a period of time, there will be a 1.5% per month (18% per year) finance charge added to any balance open after 30 days.

Minor patients of divorced parents:

A divorce decree is a legal agreement binding only upon the two parties who made the agreement. Regardless of whom the judge deemed financially responsible for dental bills, the parent who brings the child to the office for dental treatment is responsible for payment at the time of service. The parent can settle the financial responsibilities between themselves. Do not ask us to do this for you.

Dental Insurance:

We will accept your insurance as **partial payment** for your child's dental treatment, provided you have the following:

1. *Proof of insurance coverage.*
2. *An insurance claim form for each member of your family undergoing treatment with the required information completed in the **EMPLOYEE** section of our Patient Information Form.*
3. ***An insurance plan/form that provides for assignment of benefits to our office.***
4. *Signature of the insured wherever necessary.*
5. *Proof that your deductible has been met.*

If you do not provide us with this information, you will be responsible for all charges.

To determine exactly what benefits you qualify for under your plan, it may be necessary to submit to your insurance company a "predetermination of benefits". If you wish to begin treatment before the insurance company defines your exact benefits, you will be required to pay 50% of the fee for your child's dental treatment at each visit. Once we receive notice of reimbursement from the insurance company, we will adjust your payments accordingly.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the above financial policy. I understand and agree to this financial policy.

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Signature - Responsible Party **Date**