A to Z Pediatric Dentistry
Financial Policy

Thank you for choosing **A to Z Pediatric Dentistry** as your dental care provider. We are committed to providing the best treatment for our patients.

Note that within our practice we have determined a policy for payment of dental treatment which includes your understanding that all charges which are due by you are the responsibility of the party who has accompanied the patient to our office and payment is due at the time of treatment.

Please understand that payment of your bill is part of your treatment. Your Dental Insurance Plan is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you we will file your insurance claim at no charge. However, this courtesy does not relieve you of your responsibility to pay co-pays, deductibles, coinsurance, and amounts not covered by your insurance. **All patient portions are due on the date of service.** In the event that your insurance does not pay for treatment you will be sent a statement that must be paid within 30 days.

In the event your insurance changes or is terminated, it is your responsibility to provide us with new information. If claims are not paid by your insurance company within 45 days, responsibility for payment will be turned over to you and is due at that time. **Balances over 30 days will be subject to a 3% service charge per month.** If you default on payment all collection and/or legal fees incurred will be your responsibility.

All checks returned for Non-Sufficient Funds will carry a charge of $40.00 plus any additional banking fees.

HIPAA – Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy and Practices is a federal program that requires all Dental/Medical records and other individually identifiable health/dental information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. One of the main goals of HIPAA is the prevention of healthcare fraud.

I have read and acknowledge the HIPAA notice for my **child/children**:

_____	_____	_____
Child Name: first and last	Child Name: first and last	Child Name: first and last

I give consent and authorization of the HIPAA notice to the office of Dr. Joel R. Clark & Dr. Trevor M. Jensen and Staff. I also acknowledge that I have read and understand the Financial Policy of this office:

_____ _____

Parent/Guardian Signature **Dated**