KINGWOOD
pediatric
dentistry

Financial Policy

Payment is due at the time services are rendered. We accept cash, check, MasterCard, Visa, Discover and American Express. Please be aware that the parent bringing the patient to our office is responsible for payment of all charges. If someone brings the patient to our office other than the parent, arrangements for payment should be planned accordingly.

We are happy to accept insurance assignment. You must 1) Pay the estimated difference between what your insurance covers and the actual charges incurred. 2) **After insurance pays, you are responsible for the balance in full upon receipt.** 3) If insurance payment is not received from the insurance company within 5 weeks of submission, you will be expected to pay for all dental services rendered. In the event of a duplicate payment, you will be reimbursed by Kingwood Pediatric Dentistry. 4) **We attempt to provide the most accurate information available. However, insurance carriers will not guarantee their information so we regret that we can not be responsible for any discrepancies in benefits estimated. Information given to you by our office regarding your benefits is a courtesy; you should verify and be knowledgeable about you insurance benefits.** 5) Your insurance is a contract between you, your employer, and the insurance company. **We are not a party to the contract.** 6) If the recommended treatment involves some type of appliance, insurance assignment may not be accepted, and you will be expected to pay 50% when the impression of your child's teeth is taken, and the remaining balance is due the day the appliance is delivered. 7) **Should any outstanding balances not be paid after three written notices, the account will be sent to a collection agency. Costs incurred from the collection agency will be added to your balance.**

I UNDERSTAND THE FINANCIAL/INSURANCE ASSIGNMENT POLICY FOR KINGWOOD PEDIATRIC DENTISTRY. AND HEREBY ASSIGN ALL DENTAL BENEFITS TO WHICH I AM ENTITLED TO: KINGWOOD PEDIATRIC DENTISTRY. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THE ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT. **I AGREE AND ACCEPT THE ABOVE POLICY AND WILL ABIDE BY SUCH. ALL OF MY QUESTIONS REGARDING THIS POLICY HAVE BEEN ANSWERED.**

Signed_____ Date_____