Written Financial Policy

Thank you for choosing Precious Pearls Pediatric Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. The following is a statement of our financial policy which we require that you read and sign prior to any appointment.

Payment Options:

- Cash, Check, Visa, MasterCard, American Express or Discover Card.
- Precious Pearls Pediatric Dentistry charges $35 for returned checks.

Please note:
Precious Pearls Pediatric Dentistry requires payment at the time of your treatment. This is a written and signed agreement between the parent or guardian and the office rendering services. Understand that regardless of any insurance status, you are responsible for the balance due on your account. Therefore, both parents are coequally responsible for any account balances and fees at the time of your appointment or after.

Appointment Cancellation Policy: A fee of $50 per child is charged for patients who miss, cancel, or reschedule an appointment on the appointment date. A fee of $75 per child will be charged for patients who repeatedly miss, cancel, or reschedule an appointment the same day.

Insurance: For patients with dental insurance PLEASE UNDERSTAND that as an out of network provider we file and submit your claims as a courtesy to you. Kindly be informed that due to inflation and rising costs in healthcare our rates have increased. We are not responsible for how your insurance company processes claims including applicable plan maximums, limitations, deductibles and copayments. While we can assist you in estimating your portion of the cost for services rendered, we at no time guarantee payment from your insurance. It is your responsibility to ensure that your insurance is active and that your child is eligible under your plan. Also to be aware of any deductible and copayment due at the time of your appointment.

By law your insurance company is required to process a claim within 30 days of receipt. We file to all insurances electronically, so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after your insurance has processed a claim regardless of any concerns or consideration. If you have not paid your balance within 2 weeks of the statement date, we will process the card on file for the remaining balance. Any declined payments will result in a late charge fee of $20.

All outstanding balances including copays are due at the time of your visit. Please be aware of your insurance details including plan type, maximums, limitations, coverage and benefits. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____ _____

Parent or Guardian Signature **Date**

_____ _____

Patient(s) Name (CHILD)

Please note a signature attesting that you have read and understood the contents of this form is required.

Please turn over →

Credit Card Authorization Form

Please complete all fields. You may update this authorization at any time by contacting us. Please note that if you are providing an FSA card, we will require a second card on file. The second card will only be charged if your FSA card does not have sufficient funds. Please be advised, the alternative to providing a CC on file is processing full cost of appointment upfront at the time of your visit(s).

Credit Card #1 Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX □ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV code: _____
Cardholder ZIP Code (from credit card billing address): _____

Credit Card #2 Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX □ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV code: _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Precious Pearls Pediatric Dentistry to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Parent or Guardian Signature **Date**

_____

Patient(s) Name (CHILD)