

# 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 in a safe environment. The following is a statement of our financial policy which we require that you read and sign prior to any appointment.

## Payment Options:

- Online Payment via Secured Email Link.
- Cash, Check, Visa, MasterCard, American Express or Discover Card.
- Precious Pearls Pediatric Dentistry charges \$35 for returned checks.

Please note: This is a written and signed agreement between the parent or guardian and Precious Pearls Pediatric Dentistry. All communication regarding consent for services, account balances, or additional patient and insurance information should be managed between policy holder and parent or guardian present at the time of the appointment. In additional parent, guardian and policy holder are equally responsible for any account balances and fees at the time of your appointment or after.

Appointment Cancellation Policy: A fee of \$75 per child is charged for patients who miss, cancel, or reschedule an appointment on the appointment date. A fee of \$100 per child will be charged for patients who repeatedly miss, cancel, or reschedule an appointment the same day.

Insurance: Understand that as an out of network provider we are not responsible for how your insurance company processes claims. 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. Your dental insurance is a contract between you and your insurance carrier; therefore, you are ultimately responsible for payment in full of your account. Please be aware if the insurance company does not pay within 90 days, payment in full is expected from you including any applicable fees. Precious Pearls Pediatric Dentistry can determine at any time to charge upfront for services rendered. Kindly be informed that due to inflation and rising costs in healthcare our rates have increased, insurance companies pay on a usual and customary fee schedule by signing this agreement you acknowledge the fees charged by the Doctor are the indisputable fees. You are responsible for all differences between our office fee's and your insurances maximum allowance. Please note that if your child has been referred by another dentist your insurance may not cover the cost of the exam, or x-rays due to plan limitations, and it is your responsibility to pay at the time of your appointment. It is your responsibility to ensure that your insurance is active and that your child is eligible under your plan.

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, consideration or insurance disputes.

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. All outstanding balances will be invoiced via EMAIL after your insurance has processed your claim. If a balance payment is not received within two weeks from the statement date an additional \$75.00 late charge per account will be invoiced and any overdue balances over 90 days will be subject to additional fees.

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**Parent or Guardian Signature**

**Date**

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**Patient(s) Name (CHILD)**

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