Financial Agreement

972.608.4746
972.608.4749 fax

Thank you for choosing us for your child's dental care. Dr. Ryan and the staff of Grin Pediatric Dentistry have been specially trained to provide comprehensive dental care for your child (ren) in a fun and educational environment. To minimize administration costs, we ask that you be aware of the following:

A. **Insurance:** *Your insurance coverage is a contract between you, your insurance company, and your employer**. We are not a part of the contract.*** We will be happy to bill your primary insurance carrier for you; however, any co-insurance and any non-participating insurance will be due in full at the time of service. Although we attempt to estimate your portion due at the time of service, **this is only an estimate!** The exact full amount can only be determined after the receipt of insurance payments. You are responsible for filing any secondary insurance claims. In the event that your dental plan determines a service to be "not covered" you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement. _____(Initials)

B. **Missed Appointments:** Appointments are reserved in advance for your child (ren). We require that you give us a 24-hour advance notification for any scheduling change, because your child's individual appointment time with the Doctor impacts the medical and dental health of our other patients. Missed appointments will be charged at the rate of **$50.00.** _____(Initials)

C. **Returned Checks** will be subject to a $28.00 processing fee. Please be advised that if your check is returned to us for non-sufficient funds we will only accept Cash and or Credit thereafter. _____(Initials)

D. **Divorce:** In case of divorce or separation, the **parent requesting treatment** for the child will be held accountable for any charges for services rendered, regardless of a divorce decree. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the **requesting parent's** responsibility to collect from the other parent after settling their account with Grin Central Station LLP/grin pediatric dentistry. _____(Initials)

I have read and fully understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____
Signature of Responsible Party Date

_____
Please Print Name of the Patient