FINANCIAL POLICY

Children's Dental Group 8430 W. Lake Mead Blvd #150 Las Vegas, NV 89128
(702) 220-9100 Fax (702) 220-9104

This is an agreement between Children's Dental Group, as creditor, and the patient/Debtor named on this form. In this agreement the words "you," "your" and "yours" mean the insured/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us," and "our" refer to Children's Dental Group. By executing this agreement, you are agreeing to pay for all services that are received.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, The finance charge, and any payments or credits applied to your account during the month.

PAYMENT OPTIONS IF YOU HAVE NO INSURANCE:
A: You choose to pay by cash, check or credit card on the day that treatment is rendered.
B: On treatment involving surgery, the patient portion is due during the week of surgery and no later than two days before the scheduled surgery.
C: We offer special financing through Care Credit. It is interest free for three months.

PAYMENT OPTIONS IF YOU HAVE INSURANCE:
A: You choose to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, check or credit card. (NO POSTDATED CHECKS).
B: If we cannot verify your insurance for a reason that we did not have control over, payment is expected for the entire treatment, at the time of service.

PAYMENTS: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when statement issued, and is past due if not paid by the end of the month.

INSURANCE: Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

FINANCE CHARGE: A finance charge will be imposed on each item of your account which has not been paid within thirty days of the time payment is received from the insurance. In the case in which the insured needs to provide more information to the insurance company finance charge will be imposed ten days after our letter of request or statement. The finance charge will be computed at the rate of 1% per month or an Annual percentage rate of 12%. The finance charge on your account is computed by applying the periodic rate 1% to the overdue balance of your account.

RETURNED CHECKS: There is a fee $25.00 for any checks returned by the bank. And if the balance is not paid in ten days the account will be forwarded to the district attorney for further action.

MISSED APPOINTMENT FEE: Patients who do not show up on time for an appointment, or cancel with less than 24 hours will be charged $75.00 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to the collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection pf the balance to a lawyer, you agree to pay all lawyer's fees which incur plus all court costs.

WAIVER OF CONFIDENTITALITY: You understand if this account is submitted to an attorney or collection agency, the fact that you received treatment at our office may become a matter of public record.

DIVORCE: In case of divorce, the party responsible for the account prior to the divorce or separation remains responsible for those subsequent charges. If divorce degree requires the other parent to pay all or part of the treatment costs, it is authorizing parent's responsibility to collect from the other parent.

TRANSFERRING OF RECORDS: You will need to request in writing, and pay the copying fee $15.00 if you want copies of your records sent to another doctor.

CO-SIGNATURE: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

EFFECTIVE DATE: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name:_____

Responsible Party:_____

Signature:_____ Date:_____

Co-Signature:_____ Date:_____