Children's Crossing Pediatric Dentistry
1528 N. Commerce Drive Suite 100
Saratoga Springs, UT 84045
801-766-4900

Financial Agreement

Our primary goal is to provide the highest quality dental care to infants, children and adolescents. Payment for treatment is expected at the time of service. We offer the following payment options:

1. We accept cash or check
2. We accept AMEX, VISA, MasterCard and Discover Card
3. We also accept Care Credit (please ask for details)

For our families who do not have dental insurance, we do offer a cash discount of 20% when you pay your account in full on the day of service. Please ask if other arrangements are necessary.

If a patient has dental insurance, the responsible party will pay the patient estimated portion and/or deductible on the day of service. The insurance will be billed as a courtesy; however, please be aware, **if the insurance company does not pay within 60 days, payment in full is expected from the responsible party. It is the parent's responsibility to know and understand their insurance benefits.** Fees quoted in our office are estimates only. Please understand that insurance companies pay benefits based on their own fee schedule. It is impossible for us to know every insurance fee schedule and their limitations. We are always happy to submit a pre-authorization per your request if you are unsure of your coverage and limitations.

Some procedures are not covered by all insurance companies. The parent is responsible for anything their insurance does not cover. In our office, we use a white filling material. Please be advised that some insurance companies will reduce their benefit to a silver filling rate. **The responsible party must pay the difference, if any, between the two rates.**

Every 6 months children will receive a full exam, necessary x-rays, cleaning and fluoride treatment. If the patient's insurance does not cover any of these services **every 6 months**, it is the parent's responsibility to let us know before we take the child back for their appointment. Be aware that patients referred from another office may have to pay for the examination and x-rays, as limited by the patient's insurance plan.

In accordance with the Federal Truth-In-Lending Act, please be advised that interest will be charged at the rate of 18% annually on past due balances. If this account is sent to collections, we agree that in addition to any amount left owing to Children's Crossing Pediatric Dentistry, we will be responsible for interest at the rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee.

I hereby authorize Children's Crossing Pediatric Dentistry and all associates to release any and all medical and/or dental information to the insurance carrier. I hereby authorize payment directly to Children's Crossing Pediatric Dentistry and all associate's insurance benefits otherwise payable to me. I understand that I am financially responsible for any and all charges not covered by this authorization.

We require 24 hours advanced notice if for any reason you are unable to keep your scheduled appointment(s). For any cancellations outside this deadline or missed appointments without notice you will be charged $25 per appointment scheduled.

I have read and understand the above policies and accept the terms of this agreement.

Signature of authorized person: _____ Date: _____

Relationship to patient/s: _____