

**DANVILLE PEDIATRIC DENTISTRY
OZZIE JAFARNIA, DDS**

FINANCIAL POLICY

Thank you for selecting us as your child's dental home! It is our primary goal and responsibility to protect your child's smile and we wish to direct our time and energy toward obtaining that goal. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask one of our front office staff members.

Payment for services is due at the time services are rendered. We accept cash, personal checks, and for your convenience, MasterCard and Visa. If you have dental insurance, we will happily help you process your insurance claim for your reimbursement as long as we have accurate and complete insurance information so we may file your dental claims promptly.

1. If you have dental insurance, you will be required to pay your portion the day of treatment.
2. It is important to remember that your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our financial relationship is with you, and not your insurance company.
3. Remember that professional services are rendered and charged to the patient and not to the insurance company. All charges incurred are your responsibility.
4. If the insurance company does not pay your balance in full within 45 days, we will ask that you contact the carrier directly.
5. If the insurance company does not pay in full within 60 days, we will require you to pay the balance due with cash, personal check, MasterCard or Visa.
6. Balances older than 90 days may be subject to additional collection fees and interest charges of 1.5% per month or a minimum charge of \$10.00. A charge of \$50.00 will be assessed on checks returned for any reason.
7. Again, thank you for choosing Danville Pediatric Dentistry as your child's pediatric dental office. We appreciate your confidence in us and the opportunity to care for your child.

Signature: _____ Date: _____

DENTAL INSURANCE INFORMATION

Primary Policy Holder

Name: _____ SS#: _____

Employer Name: _____

Employer Address: _____

Insurance Carrier

Name: _____

Address: _____

Group/Policy#: _____

Patient ID#: _____