PAYMENT OPTION AGREEMENT

Practice Name: Henderson Pediatric Dentistry (Rhonda L. Kearney, DDS, MS, PLLC)

Treatment Plan or Financial Coordinator's Name: ____

Patient Name: ____ DOB: ________________

Person legally responsible for making treatment decisions and financial arrangements:

Name: ____

Address: _________________________City:___________________ State: ____ Zip: _______

PHONE: (Home) ________________________________ (Work) _____________________________

(Cell) ____________________________ (Email) ______________________________________

(What number may we reach you during the day: star this number * is it OK to call at work?)

Please check the appropriate box:

☐Parent ☐Legal Guardian ☐ Other: ____

We appreciate your selection of our dental office to serve your child's dental health needs. Our goal is to provide the highest quality dental care for children. At the same time, we would like to establish a healthy relationship with families, by explaining the necessary treatment and fees. In an effort to keep dental cost down while maintaining a high level of professional care, we have established the following payment options for you to choose. Please check the desired option, placing a check mark in the box. A signature is required on page two from the person making and adhering to this financial agreement.

OPTION ONE – Delta Dental, Blue Cross Blue Shield Insurance or MetLife

☐ I would like the above mentioned insurance companies to be billed electronically.
Name of recipient: ____

☐Delta Dental or ☐NCBCBS or ☐MetLife number: _________________________________

OPTION TWO – Insurance Pay per visit – estimated co-payment of 20%

☐ I would like to pay the estimated portion (i.e. 20%) at each visit by cash, check, or credit card. The insurance benefits will be assigned to the dental practice directly. Any remaining balance not covered by insurance will be paid by the responsible party in full, within 30 days of the invoice. If full payment by your dental insurance company results in a credit on your account, this will be refunded to you. You also have the option to apply any credit to future dental visits for your child or children.

OPTION THREE – Medicaid OR Health Choice

☐ I would like Medicaid or Health Choice to be billed electronically.
Name of recipient: ____

☐Medicaid or ☐ Health Choice number: ____

OPTION FOUR – Outside financing

☐ I would like to take advantage of the recommended finance company, making monthly payments to them directly for services rendered in this dental practice. I understand that financial arrangements are with the third party lender. A completed application was submitted and pre-approved on: __________________, in the amount of $_______________
Terms: ____
Name of lender: ___________________________ Account number: ____________________

OPTION FIVE – Self-pay

☐ I would like to pay for fees on the day of service.

Insurance Policy: PLEASE UNDERSTAND as a courtesy, we will assist you in filing your insurance, however we would like to emphasize that, insurance is an agreement between you, your employer, and your insurance carrier. We are not a party to that agreement and believe that your insurance should not dictate your treatment plan by the dentist. However, we will be happy to assist you in maximizing your dental benefits. Unlike medical insurance, dental insurance is a form of financial assistance and not intended to pay for care in full. We at no time guarantee what your insurance will or will not do with each claim. We also can not be responsible for any errors in filing your insurance. Once again, we file claims as a courtesy to you.

As a reminder, after full payment has been made by your dental insurance company, you will be billed for any outstanding balance due. If full payment by your dental insurance company results in a credit on your account, this will be refunded to you. You also have the option to apply any credit to future dental visits for your child or children.

> **Pre-treatment Authorization:** Some insurance companies recommend an estimate of the work to be done and the fees to be charge before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with treatment before the insurance benefit is determined.

Appliances: One-half (1/2) the cost of the appliance must be paid on the day your child's teeth impressions are taken. This is necessary because our office must pay the lab bills when appliances are ordered, not when they are completed. The remainder of the cost of the appliance is due on the day of delivery to your child.

By signing below, I (we) agree to the financial option I (we) have chosen and further acknowledge the receipt of the policies set in place. It is has been explained that any delay in treatment may result in health risks, the need for additional dental or medical procedures and associated fees that may not be covered by insurance, or any third party.

Parent/Guardian Signature: ______________________________________Date ________

Signature of the person legally responsible for making treatment decisions and financial arrangements:

____Date ________

Witnessed by: ____Date __________