Concord Children's Dental Associates
(978) 369-6248

290 Baker Avenue, S-200
Concord, MA 01742

FINANCIAL POLICY

Thank you for choosing us as the oral healthcare provider for your child/children. We are committed to providing the best dental care possible. Our fees reflect our professional commitment to excellence. Please take a few moments to read the following policy statements.

FOR PATIENTS WHO ARE *NOT* COVERED BY DENTAL INSURANCE**:**

Payment in full is required at the time of each appointment. For your convenience we accept cash, checks, Visa, MasterCard, AMEX and Discover.

Alternate financing through our office must be arranged in advance of treatment. We will be happy to provide you with an estimate of any proposed treatment.

FOR PATIENTS WHO ARE COVERED BY DENTAL INSURANCE:

We accept payment directly from most major insurance companies. All co-pays, deductibles and uncovered services are due at time of services.

Our office staffs are gladly to assist you in obtaining the maximum benefits available to you. Every insurance policy is different, and coverage varies even within the same company. **It is your responsibility to verify your insurance coverage at every appointment and to know your benefits.**

PLEASE NOTE:

- Our fees generally, but not necessarily, fall within the usual and customary fee structure determined by your insurance.
- Not all dental services are a covered benefit in all contracts. Some services, such as sealants, have age limitations for coverage. Fluoride may not be covered at each cleaning. It is your responsibility to notify us that you do not want it.
- "White fillings" are often not fully covered and may be paid at "silver filling rates", and patient is responsible for the difference

FOR ALL PARENTS:

The parent who brings the child in is financially responsible for the service. Since the vast majority of our patients are minors, we must be able to **communicate** with the parents at the time of a child's appointment. We may need to obtain permission for x-rays, update insurance information, and/or make financial arrangements. If you are unable to accompany your child for his/her appointment, please be sure we know how to contact you.

WE REQUIRE 24 HOURS NOTICE FOR ALL CANCELLATION AND RESCHEDULING OF APPOINTMENTS. A $30.00 LATE FEE WILL BE CHARGED IF LESS NOTICE IS GIVEN.

A $25.00 FEE WILL BE CHARGED FOR RETURNED CHECKS.

PATIENT NAME: ______________________________ DATE:____________________

SIGNED: ______________________________ ______________________
(Parent/Guardian) Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_________________________________, acknowledge that I have received this practice's Notice of Privacy Practices written in plain language. This notice describes how Concord Children's Dental Associates may use and disclose my protected health information, certain restrictions on the use and disclosure, and my individual rights regarding my protected health information.

______________________________ ______________________
Signature of Parent or Guardian Date

______________________________ ______________________
Signature of Adult Patient Date