Financial Policy

Dental insurance is a contract between the subscriber and the insurance company. In order to keep our fees as low as possible, payment is due prior to services rendered. In some cases we may ask that you prepay for dental services to reserve special appointment times. We will provide you with a written estimate of your financial responsibility prior to any treatment being rendered. Fees quoted are good for 90 days from the date of the estimate.

Payment for Professional services will be due in full at the time of services being rendered and are subject to change. Please have split payments arranged prior to your visit, if applicable.
Payment options are: Cash, Debit Cards, Credit Cards, and Care Credit

Claim Submission:
_______Tooth Squad Dentistry will gladly file to your insurance via electronic submission as a courtesy to you. It is your responsibility to provide our office with all the necessary insurance information prior to the appointment time and be familiar with your insurance coverage. Notification is required when dental insurance coverage or address/contact phone numbers have changed. If applicable, we will also to file secondary insurance as well. However, we will not be able to estimate benefits from secondary insurance. Payment is due based on the primary insurance estimate only.

_______Please note the entire account balance is the obligation of the responsible party. All dental services provided, whether the patient has dental insurance or not, are charged directly to the financially responsible party. This individual(s) is personally responsible for payment of all dental services. We collect payment according to the breakdown of estimated benefits provided to us by your insurance company. It is your responsibility to know your plan and its limitations, including but not limited to your deductible, plan maximum and coverage details. Estimates and fees are subject to change.

We routinely provide our patients with an estimate of cost for the proposed treatment. Since your insurance determines the benefit payable for services, our office is not responsible for 100% accuracy on what is only an estimate for treatment. Our office provides an estimate based on your insurance coverage. All insurance companies provide a disclaimer when insurance benefits are being quoted stating:
“Information is subject to change. Benefits described are not a guarantee of payment. Actual benefit payments are determined only when a claim is received, eligibility is not a guarantee of coverage.”

Assignment of Benefits:
_______We may not participate or have a specific agreement with your insurance company however; in most cases we will accept the assignment of estimated benefits. This means we will only require you to pay the estimated amount owed according to your benefit plan and will submit your claim electronically as a courtesy. Generally, the insurance company remits the expected payment within 30 days. If for any reason your insurance company fails to pay the expected amount or fails to process the payment within 60 days; you may be billed directly for the balance due. Any remaining balance difference other than the estimated on the day of service is to be paid by the financially responsible party.

Non-Assignment of Benefits:
_______There are some insurance carriers that do not accept assignment of benefits. In those cases, we may still submit claims on your behalf. However, you will be responsible for payment in full for all services rendered, due to the fact that the insurance payment is being sent directly to you. *By signing below you acknowledge that any unpaid claims over 60 days will be closed. Payment for services rendered must be paid in full prior to services being performed for non-assignment of benefits and secondary insurance.*

Delinquent Accounts:
_______There may be additional fees added to accounts which are deemed delinquent. All accounts must be paid in full to avoid additional fees and being sent to a collection agency. If an account is turned over to collection agency and or attorney for collection, the account holder will be responsible for all attorney and collection fees. Any account that is 90 days past due is subject to being sent to collections, unless other arrangements have been made.

I hereby verify with my signature below that I have read and understand the office policies stated above and also grant Tooth Squad Pediatric Dentistry and or its affiliates permission to contact me in matters related to this form.

Patient Name DOB

Responsible Party Name Date

Responsible Party Signature Date

Witness (staff member) Signature Date

Individual insurance plan coverage may be limited by your insurance company. It is the responsibility of the policy holder to be familiar with plan coverage prior to being treated for any services.
Please inform us as soon as possible of any insurance changes with your insurance.

Consent for Treatment

__________ I request and consent to the performance of comprehensive dental treatment by the treating dentist and staff. I further authorize any necessary radiographs (x-rays) and photographs needed for the diagnosis and treatment of my child's dental condition. Comprehensive dental treatment and procedures include examination, teeth cleaning, fluoride application, restorations (fillings), crowns, endodontic treatment (tooth nerve treatment), extractions, and space maintainers.
I acknowledge that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age and providing an environment likely to help children learn to cooperate during treatment.

Acknowledgement of Receipt of Notice of Privacy Practices and Consent

__________ I have received and/or reviewed a copy of Tooth Squad Pediatric Dentistry (TSPD) Notice of Privacy Practices. *You may refuse to sign this acknowledgement. Please note that refusal to sign would affect our ability to submit insurance claims on your behalf. This action would require payment in full at the time of service.

Accompanying Child Consent

__________ Initial here if no other individual can bring your child to dental appointments.

__________ I authorize the following individuals to act as appointed health care representatives with whom my child's information may be discussed. I also authorize and give consent for the following individuals to bring my child to dental appointments and make treatment decisions on my behalf.

___

___

___

Cavity Free Club/Model Photo and Video Release

__________ I hereby grant Tooth Squad Pediatric Dentistry the absolute and irrevocable right and unrestricted permission to use photos/videos taken of me or in which I may be included with others, and to use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photos/videos and in conjunction with any media now or hereafter known, and for any purpose whatsoever for illustrations, promotion, art, editorial, advertising and trade, or any other purpose whatsoever without restriction.

Text and Email Consent

__________ Tooth Squad Pediatric Dentistry can email and/or text you appointment reminders and general information about our services. If you would like to receive communications via email or text in the future, please read and sign the consent attached below.

You may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing, you consent to receiving appointment reminders and other communications/information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. By executing this consent, you assume the risk that information contained in any such communication will be intercepted. We will not charge you for sending texts or emails, but charges from your carrier may apply. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders and communications sent by our practice until I request a change in writing.

____

Patient Name DOB

____

Responsible Party Name Date

____

Responsible Party Signature Date