Financial Policy

We are dedicated to providing the best care for our patients. An essential component of patient care is good communication. Therefore, we feel it is important to clearly communicate our financial policy.

- **Your insurance is a contract between you and your insurance company**. We submit claims as a courtesy to our patients. We do not, however, know the details of your particular policy. Your coverage has been determined through negotiations between your employer and the insurance company. We will make every effort to submit a pre-estimate to your insurance company to help determine what the probable out of pocket cost will be for upcoming procedures. **This amount will be collected at the time of service. If your insurance determines that a service is not covered you will be responsible for the complete charge. For patients without insurance coverage, payment in full is due at the time of service.** For your convenience we accept cash, checks, MasterCard, Visa and Discover.

- We will send statements monthly if there is a balance due on your account. Payment is due within 30 days. If we do not receive a payment after the third statement **the account may be referred to our collection agency.**

- Payment plans are available for orthodontic treatment or extensive restorative dental work.

- **Our relationship is with the parent who usually accompanies the child to their appointments. We are not privy to the details of court orders regarding child custody or divorce agreements. NON-CUSTODIAL PARENTS WILL NOT BE BILLED WITHOUT THEIR WRITTEN CONSENT.**

- Because we value your time and ours, we require **24 hour notice for any foreseeable reason for missing an appointment.** This will enable us to better serve all our patients. **A missed appointment fee will be charged if we do not receive appropriate notice**.

If you have any questions regarding these policies please do not hesitate to contact our office manager who will be happy to talk with you.

I have read and understand the financial policy of Hopkinton Pediatric Dental Associates and agree to be bound by its terms.

Signed_______________________________________Date__________________