Dana Anthony Yip, DDS, MS
Pediatric Dentistry

Financial Policy

Thank you for choosing The Kids' Dentist as your child's oral health care provider. We are committed to the successful treatment of your child. The following is statement of our Financial Policy that we require that you read and sign prior to any treatment. Please understand that this financial policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases. We hope that you communicate with us to avoid additional fees. This also allows us to concentrate on what we do best…*caring for your child.*

Full payment is due at the time of service unless special arrangements are made.

We accept cash, checks, or most major credit cards.

Insurance: We may accept assignment of primary insurance benefits; however, we do require deductibles and co-payments be paid at the time of service. The balance is your responsibility. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract nor are we responsible for procedures that are not covered for any reason. We must have complete and up to date insurance information in order to bill your insurance company on your behalf. In the event that your insurance company has not paid their portion within 60 days, the balance will become your responsibility.
_____ **Initials**

Finance Charges:

A monthly late fee of $10 will be billed to any account in which the balance remains unpaid for 60 days without payment arrangements.

An interest charge will be added to your account balance over 60 days old. This fee will equal 12% APR.

> Unpaid Accounts: Account 90 days past due may be sent to a collection agency or settled in small claims court. In these events, you will be responsible for a $100 collection fee and/or any court fees incurred. _____ **Initials**

Missed Appointments: Unless canceled at least 24 hours in advance, our policy is to charge $50 for missed appointments. Please help us to serve you more efficiently by keeping scheduled appointments.
_____ **Initials**

Returned Checks: If a check is returned with insufficient funds, there will be a $25.00 charge, and from that point on, checks and credit cards will not be accepted. _____ **Initials**

I, the undersigned, assume financial responsibility as stated above and responsibility for all collection and legal fees if my account becomes past due. I have read, understand, and agree to this Financial Policy.

X _____ _____
Signature of Responsible Party **Date**

_____
Patient Name