FINANCIAL POLICY

We are pleased that you have chosen us for your child's dental care. We want to establish a long and pleasant relationship with you and your child. We understand that the filing of dental insurance can be a very complicated and time-consuming task. We want to assist you in any way possible to receive the maximum benefit from your insurance. We need your understanding and cooperation in the following guidelines regarding the filing of your insurance claims and payment.

1. We are contracted as a preferred provider for the following major insurance companies:
   Aetna, ALL KIDS, Ameritas, Blue Cross/Blue Shield Alabama, Cigna, Delta Dental, Guardian, Medicaid, MetLife, Principal, Southland, Standard, United Concordia and United Healthcare

   - **All applicable deductibles, co-payments and co-insurance amounts are due at the time services are rendered.**
   - **Because insurance policies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts.**
   - **Some dental services may not be covered by your contract. In the event a given procedure is not covered, payment for these services is your responsibility. We accept cash, check, American Express, Discover, MasterCard and Visa.**

2. If your insurance is through a company with whom we are not contracted:

   - Please check your contract carefully to determine if you are required to see a preferred provider for that company. Understand that if you chose to see a non-preferred provider, your insurance may not pay the full amount or pay at all.
   - Your insurance is a contract between you and your insurance company. Our office is not a party to that contract**.** **While the filing of insurance claims is a courtesy that we extend to you, ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY ON THE DATE SERVICES ARE RENDERED.**

To prevent continuous fee increases, our office does not bill or extend credit. Therefore, payment is expected for services rendered at each visit. In order to facilitate accurate and prompt reimbursement, we request that you give us complete and correct information. If your personal and/or insurance information changes, it is your responsibility to inform us. If you have any questions regarding your insurance coverage or our financial policy, please do not hesitate to ask.

Any returned checks will be assessed a $35.00 charge.
Your time is valuable as well as the doctor's time. That is why we strive to see patients in a timely manner. If you are unable to keep your appointment, please give us a 24 hour notice. Failure to do so will result in a $35 cancellation fee.
<u>A behavior management fee of $40.00 may be charged, as deemed appropriate by Dr. Bajjalieh.</u>

RELEASE (Please initial each line.)

_____I authorize Alabama Pediatric Dentistry to perform diagnostic procedures and treatments as may be necessary for proper dental care, including but not limited to use of anesthetic, radiographs and/or nitrous oxide (laughing gas).

_____I authorize release of any information concerning my child's healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

_____I acknowledge the receipt of a written copy of the Public Privacy Practices of this office in compliance with HIPPA.

_____I authorize release of any information concerning my child's healthcare, advice and treatment to another dentist.

_____I hereby authorize payment of insurance benefits directly to Alabama Pediatric Dentistry.

_____I understand that my dental insurance carrier or payor of my dental benefits may pay less that the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental carrier. I also agree to pay all costs of collections including reasonable attorney's fees and court costs and waive my (our) right(s) to claim exemption under the constitution and laws of the State of Alabama or any other state to the extent not prohibited under applicable provisions of the State of Alabama.

By my signature, I acknowledge that I have read the above office policies/statements and agree to adhere to them.

Signature of Responsible Party____Date____________________________________