Children's Corner Pediatric Dentistry
275 W 200 N Suite 175
Lindon, UT 84042
801-769-2530

Financial Agreement

Our primary goal is to provide the highest quality dental care to infants, children and adolescents. Payment for treatment is expected at the time of service. We offer the following payment options:

1. We accept cash or check
2. We accept VISA, MasterCard, Discover & American Express
3. We also accept Care Credit (please ask for details)

For our families who do not have dental insurance, we do offer a cash discount of 10% when you pay your account in full on the day of service. Please ask if other arrangements are necessary.

If a patient has dental insurance, the responsible party will pay the patient estimated portion and/or deductible on the day of service. The insurance will be billed as a courtesy; however, please be aware, **if the insurance company does not pay within 60 days, payment in full is expected from the responsible party. It is the parent's responsibility to know and understand their insurance benefits.** Fees quoted in our office are estimates only. Please understand that insurance companies pay benefits based on their own fee schedule. It is impossible for us to know every insurance fee schedule and their limitations. We are always happy to submit a pre-authorization per your request if you are unsure of your coverage and limitations.

Some procedures are not covered by all insurance companies. The parent is responsible for anything their insurance does not cover. In our office, we use a white filling material. Please be advised that some insurance companies will reduce their benefit to a silver filing. **The responsible party must pay the difference, if any, between the two rates.**

Every 6 months children will receive a full exam, necessary x-rays, cleaning and fluoride treatment. If the patient's insurance does not cover any of these services every 6 months, it is the parent's responsibility to let us know before we take the child back for their appointment. Be aware that patients referred from another office may have to pay for the examination and x-rays, as limited by the patient's insurance plan.

In accordance with the Federal Truth-In-Lending Act, please be advised that interest will be charged at the rate of 18% per annum on past due balances. The undersigned specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing fifty percent (50%) of the principal balance if the account is referred to a collection agency or attorney for collection as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I hereby authorize Children's Corner Pediatric Dentistry and all associates to release any and all medical and/or dental information to the insurance carrier. I hereby authorize payment directly to Children's Corner Pediatric Dentistry and all associate's insurance benefits otherwise payable to me. I understand that I am financially responsible for any and all charges not covered by this authorization.

There is a $25.00 charge for not showing up for scheduled appointments*. Repeated cancellations or missed appointments will result in loss of future appointment privileges.*

I have read and understand the above policies and accept the terms of this agreement.

Signature of authorized person: _____ Date: _____
Relationship to patient(s): _____
Patient names:
_____
_____
_____
_____