

Austin Childrens Dentistry OFFICE COLLECTIONS POLICY

INSURANCE BENEFITS

I understand it's my responsibility to inform and update the office (Austin Childrens Dentistry) of any changes in dental insurance coverage and also update any changes in address and contact numbers. I understand that the office requires **24 hours** notice in order to verify my child's coverage. If adequate notice is not given, I am aware that it is my responsibility to reschedule my child's dental appointment or pay the full fee of the visit.

UNPAID INSURANCE BENEFITS

All dental services provided whether the patient has insurance or not, are charged directly to the responsible patient party and that he or she is personally **responsible for payment of all dental services**. If the insurance company has not paid a claim after sixty days (60) of being submitted, the office (Austin Childrens Dentistry) will require the patient to pay the account balance unless other arrangements have been made. **It is your responsibility to know your plan and limitations including but not limited to your deductible, plan maximum and coverage details.**

TREATMENT ESTIMATES

Austin Childrens Dentistry routinely provides our patients with an estimate of cost for the proposed treatment. Since **your insurance** determines the benefit payable for services, the Office (Austin Childrens Dentistry) cannot be held responsible for 100% accuracy on what is only an estimate for treatment. The office provides **only an estimate** based on your insurance coverage. All Insurance companies provide a disclaimer when insurance benefits are quoted:

"Information is subject to change. Benefits described are not a guarantee of payment. Actual benefits payments are determined only when a claim is received, eligibility is not a guarantee of coverage."

COLLECTION ACCOUNTS

If an account is turned over to a collection agency and/ or attorney for collection, the account holder will be responsible for all attorney and/ or collections fees. **Any account that is ninety (90) days past due is subject to being sent to collections.** Unless other arrangement have been made.

I hereby verify with my signature below that I have read and understood the office policies stated above and also grant Austin Childrens Dentistry and/ or affiliates permission to contact me in matters related to this form.

Patient Name(s): _____

Signature of Parent/ Guardian: _____

Witness: _____ Date: _____