THE PASS
pediatric
dental group

Dr. Meghanne Kruizenga, D.D.S., M.S.D.
PEDIATRIC DENTISTRY

OUR FINANCIAL POLICY

Welcome to our practice! We are pleased you have selected our office for your child's dental care and we value the confidence you have expressed in choosing The Pass Pediatric Dental Group. We understand that parents are concerned not only with the quality of their children's dental care, but also the cost of professional services. Therefore, we have outlined below the financial policies of this office.

Payment is expected the day service is rendered. This includes co-payments and deductibles.

Non-insured patients are expected to pay in full with cash, check or credit card the day service is rendered. We also accept Care Credit.

For those patients who are covered by insurance, please understand that we file insurance as a courtesy. You will be responsible for any charges denied by your insurance plan. If you have any questions about your insurance and the reimbursement schedule, you should contact your insurance directly. Most dental insurance plans do not cover 100 % of the cost of your treatment. Because of this and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of charges the day services are rendered. All estimates are based on information provided to us by your insurance and are not a guarantee of payment. Only after a claim is submitted and reviewed by your insurance company can final payment be determined. We are a non-preferred provider for most PPO insurance plans and this may also affect your out of pocket cost. If you are unsure if we are a provider, please feel free to ask the front desk.

We will estimate as closely as possible your coverage, but until we actually receive payment from your insurance company, IT IS JUST AN ESTIMATE. We will assist you in dealing with your insurance company, but the ultimate responsibility lies with you. After forty-five days, any remaining balance not received from your insurance company will be due in full from you. All unpaid balances over thirty days are subject to a finance charge of 18.00% as well as a five-dollar late charge.

We charge $50 for appointments that are missed, unless a 48 hour notice was received during business hours. Please remember, once an appointment has been made this time has been reserved especially for your child.

Feel free to ask any questions that remain unanswered either before or after treatment. We wish to help you all we can.

I certify that my child is covered under the insurance company presented. I assign al insurance benefits directly to The Pass Pediatric Dental Group. I understand that I am responsible for payment of services rendered and responsible for paying the co-payment and deductible not covered by my insurance. I hereby authorize The Pass Pediatric Dental Group to release all information necessary to secure the payment of the benefits. I authorize the use of this signature on all my insurance submissions whether electronic or manual. The parent/guardian (signed below) agrees to be fully responsible for the total payment of procedures performed in this office. In cases of shared custody and/or divorce/separated parents, the parent/guardian presenting the child for treatment is responsible for the charges incurred.

I have read the above and understand this policy.

_____ Date_____

Parent or Guardian signature

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Print Patient Name