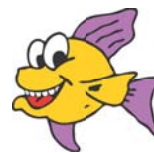


# Raleigh Pediatric Dentistry

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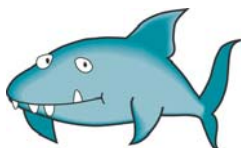


## FINANCIAL POLICY

Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment! Please understand that *payment of your bill is considered a part of your child's treatment*. The following is a supplement to our **Payment Policy**.

- Please be aware that the parent bringing the child to Raleigh Pediatric Dentistry is *legally responsible for payment of all charges*. We cannot send statements to other persons.
- **Payment is expected in full for each appointment as services are rendered**. For the convenience of our patients, we accept cash, personal checks (which **CANNOT** be post-dated), MasterCard or VISA. Additionally, we offer CareCredit for financing options.
- **Dental Insurance** - There is **NO** direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. Therefore, *we do not accept assignment of benefits from any insurance company*. Raleigh Pediatric Dentistry will submit claims as a courtesy for most insurances or provide you with a "superbill" with all applicable dental codes to attach to your insurance claim form if needed.
- **Emergency Treatment** - all emergency treatment must be paid in full at the time the service is rendered.

We recognize that under unusual circumstances an account balance may be incurred. Raleigh Pediatric Dentistry requires that all outstanding balances *be paid in full within thirty (30) days* unless other arrangements have been made. Also note, if we have not received payment or you have not contacted us within thirty (30) days, further action may be taken with a collection agency or with Small Claims Court. We reserve the right to apply an interest rate of sixteen percent (16%) from the date of service. A \$25 fee will be assessed to all returned checks. Thank you in advance for your understanding of our financial policy!



\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date