

Mentor Pediatric Dentistry, L.L.C.

Financial Policy

We are committed to providing your family with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility. To help with your investment we accept: Cash, Checks, Major Credit Cards, & Care Credit.

- We must have a completed “Patient Information Form” before we can see your child in our office, signed by a parent/guardian.
- Full payment is due at the time treatment is rendered, including deductibles and co-payments. Adult Accompanying child for appointment will be responsible for presenting a method of payment.
- A \$25.00 fee will be assessed for any returned check.
- We gladly schedule multiple siblings for your convenience; however, this does require allotting more time for the family. If appointments are broken without 24 hours notice, we will be unable to reschedule them together.
- Please be on time for your appointments – anyone who is 15 minutes late may be asked to reschedule.
- A \$25.00 fee will be assessed for all broken appointments (“no shows”) without 24hrs notice.

DENTAL INSURANCE:

We are happy to file and assist with your insurance claims for those patients with dental insurance. We do not charge for this service; however, since coverage varies with each insurance carrier, we can only approximate what percentage your carrier will cover. **Payment of the estimated uncovered portion is due at the time of the treatment.**

Deductibles and co-payments for your insurance plan are **your** responsibility.

Remember, you are ultimately responsible for your payment of service rendered in our office, not your insurance carrier. Any insurance not received to us within 30 days of treatment will be billed to you for payment upon receipt.

Insurance is a contract between you and your insurance company. We are NOT a party to the contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, etc. Most plans are designed to pay only a portion of the patient’s dental expenses (to help with expenses); therefore, **you are responsible for the timely payment of your account.**

Past due statements sent on accounts neglected longer than 90 days will be reported to a credit Bureau and will be turned over to a collection agency.

We will make every effort to accommodate your personal needs to help you adhere to our financial policy. We want to make our treatment comfortable so you can invest in the finest dentistry available for your child.

***Special Note: The parent/guardian initiating treatment will be financially responsible for the account.**

I acknowledge that I have read and agree to the above Financial Policy.

Parent/Guardian Signature: _____

Date: _____

Y. Armanzi, DDS

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