Financial Policies for Cornerstone Pediatric Dentistry

Please read and sign, indicating your understanding of the following information. If you have questions, please do not hesitate to ask. It is important that you understand these specific policies of Cornerstone Pediatric Dentistry and that you understand how your insurance company will handle your claims.

________ **It is your responsibility to provide the office with current and correct insurance information.** Failure to do so could result in your insurance company rejecting your claims for failure to obtain authorization or timely filing. In the event that this should happen you will be responsible for the incurred charges.

________ **It is your responsibility to verify your coverage and adhere to the restrictions of your plan.** Our office is a participating provider with most major insurance companies. However, some insurance companies have different tiers or have differing requirements and coverage that varies with each plan or payor. If services are performed or appointments made that are not covered by your insurance plan, you will be responsible for payment.

________ **We do not always know if you have a deductible, if your deductible has been met, or if you have co-insurance.** It is your responsibility to know this information. You are responsible for all charges that are not paid by your insurance company, including those applied to your deductible or co-insurance.

________ **You will need to sign a self-pay waiver if you have no insurance.** This waver clarifies your financial responsibility and helps prevent misunderstandings.

________ **Discounts are offered on some procedures, but ONLY if you pay at the time of service.** If you have no insurance, or if you are receiving services that are not covered by your insurance plan, you may be eligible for a discount on some dental procedures. Payment must be made at the time of service for the discount to apply. The front office staff can let you know which procedures qualify for the discount. It is your responsibility to ask the front office about the discount.

________ **If you have a co-pay or and/or estimated patient portion, you are expected to pay this when you check in for your visits.** Most insurance companies assign a patient portion to limited exams, recall appointments and operative visits. It is our responsibility to collect this at the time of service. We accept checks, cash and credit cards. Be prepared to pay when you check in for each visit.

________ **If we are a participating provider with your insurance, your agreement with the insurance company determines what you will owe for care provided.** It is your responsibility to pay your portion as indicated by the insurance company.

________ **You will be charged a $65.00 fee if you fail to show up for your appointment or if you cancel your appointment with less than 48 hours notice.** Exceptions may be made for inclement weather. The correct number to call when canceling an appointment is 303-280-5437.

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Signature of Guardian Date

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Printed name of patient(s)