JUST FOR KIDS
PEDIATRIC DENTISTRY

APPOINTMENT AGREEMENT

Thank you for choosing our office as your child's dental home! We are committed to providing the highest quality care and service to you and your family.

We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an anxious child or an emergency. Please accept our apologies in advance should this occur during your appointment. We promise to give the same courtesy to your child if they need extra care.

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. We understand there are times that rescheduling an appointment is unavoidable, however, we ask that you kindly do so by calling ***2 business days in advance*** of any scheduled appointment.

Please read and initial by each appointment agreement below:

_____ Canceling and/or rescheduling appointments without a 2 business day notice are subject to a ***$50 charge per broken appointment.***

_____ We reserve the right to NOT schedule any subsequent appointments after one (1) missed or cancelled appointments without a 2 business day notice.

_____ Multiple same day sibling appointments cancelled or rescheduled without 2 business day notice will result in all future appointments being limited to separate appointments for each child.

_____ If you arrive to your appointment more than 10 minutes late we reserve the right to only complete the services we have time to complete and/ or reschedule your appointment.

Thank you in advance for your understanding of our appointment agreement.

_____ _____

Child's Name Today's Date

_____ _____

Parent/ Guardian Printed Name Parent/ Guardian Signature

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FINANCIAL AGREEMENT

PLEASE UNDERSTAND that ***we file insurance as a courtesy to our patients.*** Please realize that your insurance policy is a contract between you, your employer and your insurance company, and not our dental office. We have no control over the terms of your contract, the methods of reimbursement or the determination of benefits. All insurance companies are different and you are responsible for knowing your provisions.

Please read and initial each financial agreement below:

_____ If we receive all of your insurance information by the day of your appointment, we will be happy to file a claim on your behalf. You must be familiar with your insurance benefits as we will collect from you the estimated amount insurance is not expected to pay at the time service is rendered. If we are unable to confirm your child's insurance is active we will collect in full for all services rendered that day.

_____ Please be aware that the parent bringing the child to any or future dental appointments is *legally responsible for payment of all charges.* We cannot send statements to anyone for the estimated out-of-pocket for services being rendered at that appointment.

_____ All estimated patient portions are due in full at the time of service. To help make payments convenient, we accept cash, check, CareCredit and all major credit cards (Visa, MasterCard, Discover, American Express). A returned check fee of $25 will be accessed for any returned check.

_____ Our acceptance of insurance assignments does not absolve you of full responsibility for the treatment rendered. In the unlikelihood that your insurance does not pay for a procedure in full, you will then be responsible for the remaining balance. If payment is not received from the insurance company in 60 days, or if an account balance remains after an insurance payment has been applied, it will be your responsibility to make payment in full within 10 days of the billing date.

MaineCare: Please read and initial each agreement below:

_____ For those patients covered by MaineCare, patients must be eligible for benefits on the date of service, otherwise the account is considered a cash account and payment is due at the time of service. If MaineCare does not make a payment for services rendered, you will be responsible for paying the balance on the account in full within 10 days of the billing date.

_____ If the patient is covered by a primary insurance company that pays the subscriber (ie: Federal Blue Cross Blue Shield), payment will be due at the time of service based on the plans reimbursement rate.

_____ Payment for all services not covered by MaineCare will be due at the time of service.

We recognize that account balances may be incurred. Just For Kids Pediatric Dentistry, P.A. requires that all outstanding balances ***be paid in full within thirty (30) days*** unless other arrangements have been made. Also note that if we have not received payment, or you have not contacted us within thirty (30) days, further action may be taken, in which a 35% collections agency fee may incur.

_____ I agree that balances be applied to my credit card on file. See Credit Card on File Form

Thank you in advance for your understanding of our financial agreement.

_____ _____
Child's Name Today's Date

_____ _____
Parent/ Guardian Printed Name Parent/ Guardian Signature