white & JOHNSON
PEDIATRIC DENTISTRY

Financial Guideline

Thank you for choosing us as your child's dental health provider. We are committed to the successful treatment of your child. Please understand payment of your bill is considered part of your child's treatment. The following is a statement of our Financial Guideline that we require you read, agree to and sign prior to beginning treatment.

Payment is due at the time services are rendered. As a courtesy to you, we will gladly assist you in the filing of your primary dental insurance. Please note we do not file secondary insurance. If we are unable to verify insurance coverage, you will be expected to pay in full for your child's visit on the day of service. If your insurance has not paid within 30 days of your child's visit, you are responsible for the balance. If your child's insurance pays more than expected a refund will be issued to you. It is also your responsibility to inform us of any changes in your child's insurance coverage.

The parent or guardian who brings the child for his/her visit is responsible for payment regardless of what individual circumstances may be or what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.

For Private Pay Patients (those not filing insurance) – we offer a 10% discount for visits over $300.00 when paid with cash in full on the day of treatment or a 7% discount for treatment over $300.00 when paying with a debit or credit card. (Excludes Care Credit).

We accept cash, money orders, Visa, Mastercard, American Express & Discover as forms of payment. We do not accept personal checks.

All accounts with an outstanding balance after 60 days of rendered treatment will be assessed a monthly non-refundable finance charge of 1.5%.

If your child is covered by Medicaid or Health Choice you must be able to provide your child's subscriber id and be active in the NC tracks system.

Treatment plan fees are valid 90 days from date of issue. Treatment must be completed within 6 months of issue date of Treatment plan. If not completed within 6 months treatment must be re-evaluated. Treatment in office is subject to change and will be verbally discussed. During Moderate Sedation and when treatment is being completed in the Operating Room, should treatment change, you will be informed after the procedures have been completed. I understand that I am responsible for any additional charges due to treatment changes.

I have read, understand and agree to the provisions of this Financial Guideline.

Signature _____

Date _____

(Signature of Person Financially Responsible for Account)

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