

Sprout Pediatric Dentistry & Orthodontics
Dr. Shaun Thompson-Banks
9025 N. Sam Houston Pkwy, Suite160
Humble, TX 77396
713-775-2888

FINANCIAL AND CANCELLATION POLICIES

PATIENT NAME: _____

1. FINANCIAL OBLIGATIONS:

The financial obligation for dental treatment is between you and this office and is not dependent upon insurance coverage. Payment for dental services is due at the time when treatment and services are rendered. Our professional services are rendered to the patient, not to the insurance company. Therefore, the patient is responsible for any applicable deductible and co-payments at the time of treatment. Any insurance disallowance over \$10.00 will be the patient's responsibility. If the insurance company has not paid within 45 days after the day of service, the patient will be required to pay the insurance portion and settle the claim directly with the insurance company.

2. PAYMENT OPTIONS:

Specific payment options will be discussed on an individual basis. Payment options may include cash installments based on your treatment, third party financing, and insurance coverage. We accept cash, personal checks, and most major credit cards including VISA, MasterCard, and American Express.

NOTE: We do NOT offer any payment plans through this office. Patients may apply for a third party financing plan such as Dental Fee Plan or Capital One. Applications are available in our office.

3. INSURANCE FILING:

As a courtesy to our patients, we file insurance claims and wait for the insurance portion payments. The patient is responsible for providing proof of insurance before all appointments. If the insurance company has not paid within 45 days after the day of service, the patient will be required to pay the insurance portion and settle the claim directly with the insurer.

Note: Any applicable insurance co-payments, deductibles, and any portion of the payment due, for treatment & services not covered by your dental insurance company are collected at the time service.

4. APPOINTMENT CANCELLATION POLICY:

We try very hard to keep to our schedule for our patients, and hope our patients try as well. Since we would reserve a place for you and other patients on the day and time of your appointment, we ask you to please give us at least 48 hours advanced notice if you are unable to keep your appointment. Only in this manner we are able to provide the optimum treatment our patients demand and deserve.

NOTE: We understand there are emergencies. However, we reserve the right to bill your account \$50.00 or 10% of your appointment fee, whichever is greater, when you fail to give us 24 hours notice that you will be unable to keep your appointment.

Our staff has made a promise, professionally and personally, to give you the concern, respect and care that makes our office a comfortable and pleasant place to visit. We ask that you give us enough warning if you are unable to keep your scheduled appointment so that we can treat another patient.

5. DELINQUENT ACCOUNTS:

If your account becomes delinquent and it is turned over to a collections agency, additional finance charges may be applied to your account.

I am aware and accept my financial obligations and agree with the financial and cancellation policies mentioned above.

Signature: _____

Date: _____