VALLEY DENTAL PEDIATRICS
139 N. JENSEN ROAD
VESTAL, N.Y. 13850
(607) 754-3903

FINANCIAL AGREEMENT

PAYMENTS: FEES FOR TREATMENT ARE DUE IN FULL AND PAYABLE AT TIME OF SERVICE FOR ALL PRIVATE PAY PATIENTS OR PATIENTS WITH INSURANCES THAT ARE OUT OF NETWORK. FOR YOUR CONVENIENCE, WE HONOR MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS AS WELL AS CASH OR PERSONAL CHECKS WITH PHOTO ID. IN ADDITION, WE OFFER AND ACCEPT CARE CREDIT.

MEDICAID/HEALTHPLEX: IF YOU HAVE A PRIMARY INSURANCE, YOU ARE IN AGREEMENT TO TURN OVER ALL INSURANCE PAYMENTS WITH THE EXPLANATION OF BENEFITS FORM MADE PAYABLE TO YOU TOWARDS CHARGES INCURRED BY YOUR CHILD/CHILDREN WITHIN A 30 DAY TIME FRAME SO THAT WE MAY BILL YOUR SECONDARY MEDICAID/HEALTHPLEX INSURANCE WITHIN THE REQUIRED TIME FRAME. FAILURE TO DO SO MAY RESULT IN THE DISMISSAL OF YOUR CHILD/CHILDREN FROM THIS PRACTICE WITH LEGAL REPERCUSSIONS TO COLLECT FULL PAYMENT FROM YOU. YOU SHOULD ALWAYS BE AWARE THAT YOUR INSURANCE PLAN IS A PLAN BETWEEN YOUR INSURANCE COMPANY AND YOU AND MAY NOT ALWAYS COVER ALL FEES. IN TURN YOU ARE RESPONSIBLE TO PAY THE REMAINING BALANCE NOT COVERED BY YOUR INSURANCE.

DENTAL INSURANCE: WE DO PARTICIPATE WITH MOST INSURANCE COMPANIES BUT YOU SHOULD ALWAYS BE AWARE THAT YOUR INSURANCE PLAN IS A PLAN BETWEEN YOUR INSURANCE COMPANY AND YOU AND MAY NOT ALWAYS COVER OUR NEGOTIATED FEES BASED ON THAT PLAN. IN TURN YOU ARE RESPONSIBLE TO PAY THE REMAINING BALANCE NOT COVERED BY YOUR INSURANCE. IF YOU HAVE INSURANCE WITH A COMPANY WE ARE OUT OF NETWORK WITH THEN IT IS THE POLICY OF OUR OFFICE TO MAKE FINANCIAL ARRANGEMENTS WITH YOU DIRECTLY, SINCE YOU ARE RESPONSIBLE FOR THE CHARGES. BENEFITS FROM YOUR INSURANCE COMPANY WILL GO DIRECTLY TO YOU FOR INSURANCES WE ARE NOT IN NETWORK WITH. OUR OFFICE WILL SUBMIT THE REQUIRED BILLING INSURANCE FORMS TO THE INSURANCE COMPANY FOR YOU. WE ASSUME NO RESPONSIBILITY FOR THE AMOUNT OF INSURANCE COVERAGE OR DELAY IN REIMBURSEMENTS.

PAST DUE ACCOUNTS: SHOULD YOUR ACCOUNT BE TURNED OVER TO A COLLECTION AGENCY OR ATTORNEY, YOU AGREE TO BE RESPONSIBLE FOR ALL COLLECTION COSTS OR ATTORNEY FEES INCURRED. A 30% COLLECTION FEE IS CHARGED TO ALL UNPAID BALANCES. IN CASE OF SUIT, YOU AGREE THE VENUE SHALL BE IN BROOME COUNTY COURT, NEW YORK.

WAIVER OF CONFIDENTIALITY: IN ANY EXTERNAL COLLECTION ACTION REGARDING YOUR ACCOUNT, YOUR FILE MAY BECOME A MATTER OF PUBLIC RECORD.

RETURNED CHECKS: THERE IS A $20.00 CHARGE FOR ALL RETURNED CHECKS.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: I AUTHORIZE VALLEY DENTAL PEDIATRICS TO RELEASE TO MY INSURANCE CARRIER SUCH INFORMATION AS MAY BE NECESSARY FOR THE COMPLETION OF MY TREATMENT CLAIMS AND ASSIGN TO VALLEY DENTAL PEDIATRICS BENEFITS FOR SUCH CLAIMS.

AFTER HOUR FEE: THE FEE FOR AN AFTER HOUR EMERGENCY VISIT IS $155. THIS CHARGE MAY OR MAY NOT BE COVERED BY YOUR INSURANCE COMPANY. IF IT IS NOT A COVERED CHARGE, YOU ARE SOLELY RESPONSIBLE FOR PAYMENT.

APPOINTMENT POLICY: THERE ARE MANY CHILDREN IN NEED OF CARE IN OUR OFFICE. WE RESERVE TIME IN OUR SCHEDULE TO MEET THE NEED OF AS MANY CHILDREN AS WE CAN EVERY DAY. TO HELP US CONTINUE TO MEET THAT GOAL, WE REQUIRE AT LEAST A 24 HOUR NOTICE IF YOU NEED TO CHANGE OR CANCEL AN APPOINTMENT. WITH THAT IN MIND, IF YOUR FAMILY MISSES A TOTAL OF 2 APPOINTMENTS WITHOUT CALLING PRIOR TO THE RESERVED TIME, YOU WILL BE DISMISSED FROM OUR PRACTICE.

I HAVE READ AND UNDERSTAND THE FINANCIAL AGREEMENT AND APPOINTMENT POLICY,

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(DATE) (PATIENT OR LEGAL GUARDIAN SIGNATURE)

(PATIENT DATE OF BIRTH)	(PATIENT NAME)
(PATIENT DATE OF BIRTH)	(PATIENT NAME)
(PATIENT DATE OF BIRTH)	(PATIENT NAME)
(PATIENT DATE OF BIRTH)	(PATIENT NAME)
(PATIENT DATE OF BIRTH)	(PATIENT NAME)