CAPITOL HILL PEDIATRIC DENTISTRY

650 PENNSYLVANIA AVE, SE SUITE 220 WASHINGTON, DC 20003
P (202) 849 - 3292 F (866) 727 – 8958

Capitol Hill
pediatric dentistry

Financial Agreement

Payment Due At Time of Service

The front desk staff will estimate the amount the patient owes for procedures the dentist or hygienist have completed, or those procedures that are in process. Remember, this is only an estimate. The actual out-of-pocket expense may be less or greater than the amount estimated and collected. The patient may be reimbursed or apply the excess amount to another date of service. Some insurance plans require the patient to pay only a copayment for specific procedures. Some plans require the patient to pay the entire amount due for that visit. We will work with your plan, and submit the claim and necessary forms to receive the reimbursement, as a service to our patients.

Insurance Coverage

Our office accepts many different insurance plans, which include most PPO plans. All plans have an allowed amount of covered services. There is no guarantee that services will be covered. The responsible party on the patient's account will be responsible for payment of non-covered procedures. If you wish, you can request a predetermination for any major work to your insurance carrier. The advantage of this is knowing approximately what your out-of-pocket expenses may be for future charges. This will provide an approximation of your out-of-pocket expenses for planned treatment.

Cancellation Policy

Our office requires patients to reschedule or cancel appointments 48 business hours in advance of the scheduled visit. After one missed appointment, there may be a $45.00 charge per 30 minute appointment. Charges may be higher for restorative visits. The patient may not be rescheduled until this fee is paid. Patients will be dismissed after multiple missed appointments not due to unforeseen circumstances.

Finance Charges

Payment is expected at the time of services rendered. Any outstanding balance which is overdue by more than 30 days will be considered late. A late balance will be sent to collections after 90 days. A monthly payment plan may be made available. For more information, please speak to the front desk staff.

I, _____ understand and agree to the financial policies of Capitol Hill Pediatric Dentistry. I agree to pay any copayments and deductible fees due at the time of service.

_____ _____

Patient/legal guardian Signature Date