

## Patient Financial Policy

*Welcome to Shoal Creek Pediatric Dentistry, the office of Dr. Scott Thomas. Please feel free to ask any questions you may have regarding this form or any other aspect of your child's appointment.*

### **Our Policy requires payment at the time of service for your visit.**

If the patient does not have dental insurance, payment in full is expected on the day of service, unless other arrangements have been previously made.

If you are a member of a medical Insurance Plan and have chosen us as a provider of your care, you are responsible to:

- Provide us with information relative to your claim, including insurance card, number, employer, birth date, and address and Social Security number. This information is requested on the Patient Registration form, which we ask that you complete during your initial or subsequent visit.
- Pay your deductible and/or coinsurance at the time of service.
- Pay for services not covered by your insurance carrier.

### **Insurance claims for your carriers are filed as a courtesy at no charge to you.**

- To assist you with your payment, our office accepts Cash, Care Credit, Cashiers Checks, Money Orders, Travelers Checks, Visa, Mastercard, Discover, and American Express.
- Personal checks are accepted with proper identification (driver's license or photo ID). A \$30.00 returned check fee will be added to returned checks plus applicable bank charges.
- Care Credit is a convenient, low minimum monthly payment with no interest, program for your entire family designed to pay for healthcare not covered by insurance. Visit [www.carecredit.com](http://www.carecredit.com)
- When your bill is unpaid, a collection agency may be chosen to manage delinquent accounts. If your account is placed with a collection agency, you will be responsible for all costs of collection. Services are rendered to the patient and not to an insurance company, therefore the person responsible for the account is responsible to Shoal Creek Pediatric Dentistry for payment.

## Cancellation Policy

- We require a 24 hour cancellation notice for a scheduled appointment.
- Patients who fail to show for their scheduled appointment without giving due notice will be charged a \$25.00 fee. This is not payable by your insurance.

*I have read and fully understand my financial responsibilities under this policy.*

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

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