Hamilton Pediatric Dentistry, PC
3299 Clear Vista Ct.
Suite B
Grand Rapids, MI 49525
Phone: (616) 608-6826

Office Financial Policy

Child's Full Name_____

We appreciate you allowing us to provide dental care for your child. Because we value our relationship with you and we believe that the best relationships are based on understanding, we offer clarifications of methods of payment for services.

- We will be happy to file your insurance claim on the first visit if we have received all of your insurance information. You will need to be prepared to pay any amount that is determined not payable by your insurance plan, such as deductibles and percentages.
- We request that estimated co-pays are collected in full by cash, check, or charge/credit card at each appointment as service is rendered. Estimated co pays are collected in full by cash, check or credit/charge cards at each appointment as service is rendered is requested. For your convenience, Visa, MasterCard and Discover are accepted.
- The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.
- To ensure prompt and efficient patient care, we require 24 hour notice to reschedule or cancel appointments. A $50.00 reactivation fee may be assessed in order to reschedule if 24 hour notice is not given.
- We are dedicated to providing the best treatment for our patients and our fees are based on the most appropriate treatment for your child. Please note the following:
    1. We must emphasize that as health care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer, and the insurance company. We are not a part to that contract.
    2. The amount not covered by your insurance is payable at the time of service, such as deductibles and co-payments. However, if we do not receive payment from the company within 45 days after the submission of a claim, you will be expected to pay for all dental services in full within 10 days of notification. In the event of duplicate payment, you will be reimbursed.
    3. You are responsible for payment regardless of any insurance company's arbitrary determination of fees. Please be aware that some services provide may be a non-covered service by your dental insurance carrier.
    4. All charges for services rendered that remain unpaid 30 or more days will be subject to a 1.5% monthly finance charge/late fee (18% annually) or a minimum monthly finance charge/late fee of $25.00, whichever is greatest.
    5. A charge of $25.00 will be assessed on any returned check.
    6. Should your account be turned over for collection, you will be responsible for all cost of collection, without limitation, attorney's fees, and court costs.

We will do our best to maximize the insurance benefits that you are eligible to receive and we do appreciate your prompt settlement of any charges that may be incurred during treatment. We look forward to years of close association with you as we work together to maintain your child's oral health.

I have read and understand the Office Financial Policy and agree to abide by its contents.

Parent/Guardian: _____Date: _____