SANDHILLS PEDIATRIC & FAMILY DENTISTRY
FINANCIAL RESPONSIBILITY

Payment is due at the time of service. We accept cash, debit cards, VISA, Mastercard, Discover and CareCredit as means of payment. As a courtesy, if you have dental insurance, we will file it for you. We encourage you to become familiar with the limitations of your dental plan (i.e., coverage, deductibles, frequencies of procedures and co-payments), as we will collect your cost share the day of service. On average, insurance claims are paid within 30 – 45 days. If your insurance claim is not paid within that time, you will receive a bill for payment. Upon receipt of payment from your insurance, we will kindly remit the credit balance to you. Your account will be assessed additional fees and collection charges of 1 1/2% if not paid within 30 days.

To avoid broken appointment and cancellation fees, we request a 24-hour courtesy call to cancel your reservation with us. A 48-hour courtesy call is requested for Saturday and appointments requiring an extended amount of time (i.e., root canal therapy; IV sedation; oral sedation; oral surgery). You will be advised of the proper cancellation policy when you schedule your appointment.

SANDHILLS PEDIATRIC & FAMILY DENTISTRY
AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and accurate. It is my responsibility to inform Sandhills Pediatric and Family Dentistry, Brooks and Dunston DDS, PLLC of any changes in my personal information (i.e., telephone number, address, insurance carrier, and/or health). I understand that I am financially responsible for all charges, whether paid by insurance or not, at the time services are rendered. I authorize the use of my signature and authorize this office to submit claims and assign benefits on my behalf to _____ Insurance Company. Sandhills Pediatric and Family Dentistry, Brooks and Dunston DDS, PLLC may use my health care information and may disclose information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient _____ Date _____

Signature of Parent or Legal Guardian
_____ Date _____