

**1367-B EAST GARRISON BOULEVARD  
GASTONIA, NC 28054-5144  
980.320.8479  
WWW.GASTONIAPEDIATRICDENTISTRY.COM**



## Financial Policy

Thank you for choosing us as your dental healthcare provider. We are committed to providing you with the highest quality care in a compassionate, professional, and timely manner.

Payment in full is required at the time of service for non-insured patients. Payment of estimated portion and/ or co-pays (or the balance in full if your carrier will not reimburse us directly) is required for insured patients at the time of service. In-house payment plans are not available. However, patient financing programs are available through a third party.

Any estimate given on any treatment needed is subject to change if additional information is revealed through further clinical examination or radiographs. Once a patient is aware of what is taking place and allows treatment, patient is responsible for payment of additional treatment.

Our practice is not a preferred provider for every insurance carrier. We will file any insurance claims as a courtesy to you. The benefit percentages quoted are based on "UCR" or "usual, customary, reasonable" and are determined by your employer and the carrier; but not by what we determine our fees are here at Gastonia Pediatric Dentistry.

Your dental insurance plan is an agreement between your employer and its selected insurance company. Dental care is provided to the patient, not to the employer, nor to the insurance company. As a result you are responsible for payment in full for services rendered. We will accept assignment of benefits to come to us as your provider. Any balance that results from your carrier's denial or deviation from the estimated treatment plan presented remains your responsibility. Any account for which an insurance claim has been filed and has not been paid after 90 days may be subject to the provisions set forth as stated below.

A monthly finance charge of 1.5% (18% annually) is applied to accounts with any portion of the balance greater than 90 days past due. Any account that remains unpaid after 90 days will incur a finance charge and may be transferred to a third party for collection and/or legal action. If legal action becomes necessary in the collection of a delinquent patient account, in addition to the aforementioned charges, the patient will accept responsibility for the attorney fees and/or legal fees and costs of collection.

A returned check charge of \$25.00, of the maximum allowed by North Carolina State law, will be issued to any account on which payment has been refused by the payer bank because of insufficient funds or because the drawer did not have an account at that bank.

Our protocol for missed appointments is as follows: For patients who (1) are chronically late, (2) frequently fail to show, or (3) chronically reschedule or cancel on the day of appointment, a pre-deposit may be required before scheduling and/or may result in dismissal from the practice.

By signing below the patient or responsible party accept the terms of this financial policy.

Patient Name \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

