**KEMIE D. HOUSTON,** D.D.S., M.S., P.C.
Board Certified Pediatric Dentist

# Pediatric Dentistry

## FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a relaxed and informative environment. The following information is provided to develop a mutual understanding of important financial issues prior to treatment. If you have any questions, please do not hesitate to ask.

### PAYMENT

Payment or insurance co-payments are due at the time services are rendered. Please be aware that the parent bringing the child is responsible for payment of all fees. **WE WILL NOT INTERVENE WITH DIVORCE ISSUES.** We accept all major credit cards and offer CareCredit for anyone requiring a payment plan. New patient emergency visits require payment in full at the time of appointment. Insurance payment will be directed to you or reimbursed to you upon receipt.

### BILLING FEES

A charge of 1.5 % of balances will be added to your account if not paid within 60 days, even if your insurance has not paid. There will be a $50.00 charge for returned checks. Missed appointments without reasonable excuse may incur a $50.00 fee for the doctor's time. Please give the office 24hours notice if you are unable to keep your reserved appointment time. Should this office be required to employ an attorney or collection service to collect delinquent payments, the responsible party agrees to pay all reasonable collection costs and attorney fees.

### DENTAL INSURANCE

As a courtesy, we will file a claim to your insurance if complete, accurate billing information is provided. Insurance is a contract between you and your employer. Therefore, it is your responsibility to see that your insurance company pays in a timely manner. It is important that you are aware of what is covered by your plan and how benefits are paid. We would be happy to assist you with obtaining this information, but you should be provided this information prior to the effective date of coverage by your employer. We are not responsible for how or what your insurance pays.

### AUTHORIZATIONS

1. I authorize payment of dental benefits otherwise payable to me, to be directed to Kemie D. Houston, DDS, MS, PC

2. I authorize the use and disclosure of any information concerning my case to my insurance company by Kemie D. Houston, DDS, MS, PC

3. I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

Patient Signature or Responsible Party if Minor Date

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