Tyler Carter, DDS
Diplomate, American Board of Pediatric Dentistry

Randy Weinshel, DDS
Diplomate, American Board of Pediatric Dentistry

KIDS FIRST PEDIATRIC DENTISTRY

The Road to a Lifetime of Smiles

Our philosophy is to provide a positive dental experience and the highest quality of dental care to our patients. To ensure you begin with a positive experience we have prepared the following information for review in advance of your child's dental visit. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT

In order to keep our fees as low as possible we ask that all co-payments be paid at the time of service. For your convenience an ***ESTIMATE*** for dental care will be prepared prior to scheduled appointments to ensure you the opportunity to plan in advance for your child's dental care.

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Initials

DENTAL INSURANCE

We are happy to file dental claims to assist you in receiving the full benefits of coverage as your plan outlines. We request that you familiarize yourself with your child's insurance benefits and provide us with correct information to assist with the submittal of your child's claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received within 45 days. Please remember that your insurance is a contract between you, your employer, and the insurance company; therefore, we ***CANNOT GUARANTEE*** any estimated coverage. Not all services are covered benefits in all contracts; therefore, YOU are ultimately responsible for the total amount due. Recommended dental care is indicated based on individual patient needs regardless of dental insurance benefits, deductibles, limitations, or maximums.

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Initials

DELINQUENT ACCOUNTS

Account balances should be paid within 30 days of the account statement to avoid a one-time $20 late fee. There will be a $25 service fee for any check returned from our financial institution.
Outstanding balances after 90 days will be transferred to a collection agency unless prior arrangements have been made. I further agree to pay all finance charges, collection fees, attorney fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

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Initials

I have read and understand the **HIPPA/PRIVACY POLICIES**

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My signature indicates that I understand the policies as outlined and my questions have been answered.

_____ _____ _____
Patient Name | Signature of Responsible Party | Date

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