



LAURENCE A. DARROW, D.D.S.
SIMON P. MORRIS, D.D.S.

Our Financial Policy

Thank you for choosing us as your dental care provider for your child. We are committed to your child's treatment being successful. Please understand that payment of your bill makes it possible for us to remain a viable dental practice. The following is a statement of our Financial Policy, which we require you to read and sign prior to any dental treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD

REGARDING INSURANCE

It is important that you provide us with accurate information. We will be happy to bill your insurance if you provide all the necessary information. (In some cases where coverage is different for children in a family, we may not be able to bill for you.) Any insurance that needs to be rebilled because of incorrect information will be subject to a resubmission fee of \$5.00.

We may accept assignment of benefits as a courtesy to you. However, we do require your "percent" of the bill to be paid at the time of the visit whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance has not paid your account in full within 45 days, the balance becomes due. A \$5.00 late fee will be charged on accounts that are past due.

USUAL & CUSTOMARY RATES

Our practice is committed to provide the best treatment for your child and our fees are accepted as usual and customary. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

The parent of adult accompanying a minor is responsible for full payment at the time of visit.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the Financial Policy. I understand and agree to this Financial Policy.

signature of responsible party

DATE _____