WELCOME TO RIVERFRONT PEDIATRIC DENTISTRY

Our staff are happy to assist you with your child's dental needs

INSURANCE

A common question at any health care facility is, "Do you accept my insurance?" We participate with some PPO insurance's and are happy to submit claims on behalf of our patients. Please check with your insurance company to ensure coverage.

Your dental insurance plan may want you to choose your dental care from a list of their preferred providers. Whether or not you choose your dental care from a defined group can affect your level of reimbursement. Your plan may also stipulate that they will pay benefits for the least expensive alternative treatment for a condition.

As a courtesy to our patients, we will generate and submit a claim to your insurance company on the day services are rendered. **The office needs to be notified of any insurance changes at least 48 hours prior to all scheduled dental appointments for insurance verification purposes. If you cannot provide us with the necessary information, the balance will be due in full at the time services are rendered and we will generate a claim for you to submit to your insurance carrier for reimbursement purposes.** Please note that you are responsible for your estimated copay at the time of service. Also note that our estimation of your insurance coverage is not a guarantee of payment, but merely an estimate based on the best information we have. There may be a deductible, a yearly maximum, fee schedules, benefits paid to other offices or other factors considered. **Please refer any questions or verification of precise benefits to your insurance company or employer.**

Your insurance plan is a contract between your employer and the insurance company and we are not a party to that contract. The plan purchaser at your workplace makes the final decision on "maximum levels" of reimbursement through their contract with the insurance company. Please contact your insurance carrier prior to your child's first visit to ensure you have coverage with our office.

Any outstanding balance remaining on your account after 60 days will be charged to the credit card on file and you will be responsible for pursuing any outstanding insurance claims directly with your insurance company. Our office will provide you with any necessary information, claims or documentation required. We urge you to contact your insurance company to ensure prompt processing of such claims. Accounts over 90 days, are subject to a 1.5% finance charge per month.

Our recommendation of treatment for your child is never influenced by your insurance benefits. You may find that we withhold performing certain procedures that we find not necessary or indicated even though they may be covered by your insurance. For instance, not every child requires radiographs every six months or even every twelve months. A one or two year old child may not get a benefit from having a cleaning done. We only recommend treatment that we find beneficial and necessary for your child. We want every patient to feel special and important and will answer any questions you might have.

GENERAL & FINANCIAL CONSENT

I request and authorize Riverfront Pediatric Dentistry, LLC, Dr. Eyal Simchi, his associates, and staff (under his direction) to perform examination, cleaning, radiographs, photographs and fluoride treatment for my child as necessary. I understand that any further treatment needs will be explained to me prior to treatment and will require additional consent.

I state that I am the child's legal guardian and that I have read and agree to follow all office policies. This consent will remain in effect unless canceled in writing.

I will notify this office of any changes in my child's health, including current medications, allergies and any hospital stays.

I authorize Riverfront Pediatric Dentistry to release any information necessary for the processing of dental insurance claims and authorize payment directly to Riverfront Pediatric Dentistry of insurance benefits otherwise payable to me.

I acknowledge that I have read and agree with the office financial policy. **I understand that any estimate of my insurance benefits is solely an estimate and not a guarantee of payment**. I understand that this office bills my insurance as a courtesy and that I am ultimately responsible for knowing the coverage's and limitations of my plan. I also understand that my insurance company may not cover tooth colored (composite) restorations on back teeth(molars) and might pay benefits at a less expensive alternative benefit. In that case, I will be responsible for the difference in treatment cost. I also understand that other charges such as (but not limited to) nitrous oxide inhalation (laughing gas) and fluoride treatment may not be covered by my insurance and will be my financial responsibility. Initial:_____

I acknowledge that I have given the correct insurance information to the office and will notify the office of any changes in my insurance carrier at least 48 hours prior to all dental appointments. In the event I fail to notify the office within 48 hours, I am aware of my responsibility for payment in full. I also understand that fees and treatment needs are subject to change and previous estimates are not to be considered a guarantee. Initial:_____

I acknowledge that payment in full is expected in case of no insurance coverage unless prior financial arrangements have been made. Initial:_____

I agree that all balances over 60 days will be charged to the credit card on file and that I am responsible for obtaining insurance reimbursement for any outstanding claims. All accounts over 90 days are subject to a 1.5% finance charge per month. Please note that we reserve the right to charge a $50 fee per child for all missed or broken appointments when not given a 48 hour notice. There is a $35 fee for all returned checks. I understand that I will be responsible for legal or collection fees if my account becomes overdue. This consent will remain in effect unless cancelled in writing. No treatment can be rendered unless you have read and signed this form. Initial:_____

Child(ren)'s Names_____

Name of Responsible Party/Guardian_____

Name of Insurance Company_____

Signature_____ Date_____