



2702 American Street • Springdale, AR
www.KimbroughDental.com
(479)751-9899

Patient /Parent name _____ Date of Birth: _____
Dependents: _____ Date of Birth: _____
_____ Date of Birth: _____
_____ Date of Birth: _____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service is provided, unless arrangements have been made ahead of time. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, Lending Club and CareCredit. Both Care Credit and Lending Club offer interest free options.

Emergency clients: expect to make a payment in full at the time of service.

Please note: Additional fees will be applied for returned checks.

Do you have insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express, and CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Communications with you: By signing below, you are authorizing us to contact you at any number you provide including calls, text or emails. Please be specific when filling out the medical history form so that we know the most convenient way to contact you.

Patient /Parent name printed_____

Patient /Parent signature_____ **Date** _____