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**Financial Policy**

Please print this form, sign it, and bring it with you for your visit to the office

Thank you for choosing us as your child's dental health care provider. We are committed to your child's treatment being successful. Please understand that payment of your bill is considered a part of the treatment. The following is a statement of our financial policy which we require you to read and sign prior to treatment.

All parents must complete our Patient and Family Information and Health History form.

***Our policy is as follows:***

- Full payment is due at the time of service
- We accept cash, checks, or VISA / MasterCard
- We offer an extended payment plan with prior credit approval

***Regarding Dental Insurance***

We may accept assignment of insurance benefits for your child's visit. However, we do require full payment of deductible and / or co-payment at time of each service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your full insurance information. Please understand that your insurance policy is a contract between you and your insurance company and reimbursement levels are dependent upon the premiums you pay and the benefits your company negotiates. We are not a party to that contract. In the event that we do accept assignment of benefits and your company has not paid within 45 days, you will be responsible for the total amount of your balance.

Please be aware that some, and perhaps all of the services provided may be non-covered and not considered reasonable and necessary by your insurance company.

***Usual and Customary Rates***

Our practice is committed to providing the best possible dental and oral health care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of "usual and customary fees." Insurance companies may calculate their usual and customary by determining limitations on the extent or nature of treatment of services that may be provided for your child.

***Responsibility for Fees***

The adult accompanying a patient and the parents (or guardians, legal or otherwise) are responsible for full payment.

***Missed Appointments***

Because time is reserved for your child, a fee of \$50 will be assessed for a missed appointment not canceled at least 24

hours in advance. Please help us serve your child better by keeping scheduled appointments.

***Binding Arbitration***

Binding third party arbitration will be the method for resolving disagreements outlined in any section of this "Financial Policy."

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We are happy to provide any answers and are committed to making your child's and your visit as pleasant and educational as possible.

*I have read, understand and agree to this Financial Policy:*

\_\_\_\_\_  
*Signature of responsible party*

\_\_\_\_\_  
*Date*