Financial Agreement Form

Little Heroes Pediatric Dentistry

26534 Moulton Pkwy, Suite C, Laguna Hills, CA 92653

(949) 342-1484

Welcome to Little Heroes Pediatric Dentistry. We are happy you joined our dental family. We look forward to providing quality dental care to you and your children, but before we can proceed we need you to agree to the following terms:

Please understand that full payment of your account is considered part of your treatment and is required for all services rendered. Also, payment for past services rendered and treatment given is required before all future services and treatment may be made. We expect full payment at the time the services are rendered. This office accepts Visa, Master Card and Discover Card. Checks are accepted with a valid photo ID, but returned checks are subject to additional service fees. Extended payment plans may be offered with PRIOR credit approval but must be made prior to treatment. All unpaid accounts are sent to collection after payment is not made in a responsible time period and may adversely affect your credit. You agree to pay all fees incurred in the pursuit of delinquent account balances. Please understand that non-emergency services can be denied for delinquent accounts and collection action may affect your patient status with this practice. All co-payments are due to at the time of services. Responsible party agrees to pay all deductibles, coinsurance and services deemed "patient responsibility" as identified by the insurance carrier. There will be a charge of $25 for account balances of 60 days past due.

Although we make every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will pay a claim, or pay the amount estimated. Patients/Guardian are responsible for checking their benefits prior to treatment. The insurance carrier makes final determination, based upon the plans level of coverage and associated policies, upon receiving the claim. Denied claims become the responsibility of the patient/guardian.

_____ **I AUTHORIZE LITTLE HEROES PEDIATRIC DENTISTRY TO USE MY INSURANCE INFORMATION TO BILL THE TREATMENT PROVIDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE I AUTHORIZE THE USE OF MY SIGNATURE ON ALL LITTLE HEROES DOCUMENTS SUBMITTED MANUAL OR ELECTRONIC.**

_____ **I ACKNOWLEDGE RECEIPT OF DENTAL MATERIAL FACT SHEET AND NOTICE OF PRIVATE PRIVACY PRACTICES ON MY FIRST APPOINTMENT**

I have read the above information and agree to the terms and conditions contained therein.

Name _____

Signature _____

Date _____

Relationship to Patient _____