

**Margaret B. Childers, D.D.S.**  
**20919 Kingsland Boulevard**  
**Katy, TX 77450**

**FINANCIAL AGREEMENT AND AUTHORIZATION**

- 1) Patients who do not have dental insurance will receive a 15% discount on all dental services.
- 2) Payment, as arranged, is due in full at each visit with cash, check or credit card.
- 3) If you have insurance benefits and assign benefits to us, we will manage your account as follows:
  - a) No administrative fee will be assessed for filing insurance claims; we will provide this service as a courtesy.
  - b) You must provide our dental staff with accurate insurance billing information prior to your appointment, or you will be responsible for payment in full. (We verify your insurance information in advance of your appointment so we can avoid delays in estimating your benefits at the time of service.)
  - c) Our administrative staff will research insurance benefits and estimate coverage based on our insurance expertise. We do not guarantee our benefit estimates to be correct and are not responsible for benefits that are not paid exactly as estimated.
  - d) If we unable to reasonably estimate secondary insurance coverage, the office will accept assignment for only the primary insurance coverage. You must file secondary insurance coverage in this instance.
  - e) You are responsible for paying deductibles and estimated co-payments. You are also responsible for paying all charges not covered by your insurance plans, including all fees considered above your insurance policy's usual and customary fee schedule.
  - f) Information requests to you from the insurance company and/or our practice must be responded to promptly.
  - g) The office will submit a claim to an insurance company up to two times per appointment for the purpose of obtaining payment. Further insurance appeals are your responsibility.
  - h) You are responsible for insurance balances in full after 60 days, even if your insurance company has not paid. Further insurance appeals beyond the 60 day period are your responsibility.
  - i) Insurance benefits are a contract between the patient and his/her employer. The coverage a patient will receive depends upon the quality of the plan purchased by his/her employer, not the fees of the doctor. You are financially responsible for all services provided by Dr. Childers. Any insurance benefit not paid is your responsibility.
- 4) The practice will not carry balances longer than 90 days. Patients will be informed when their accounts are delinquent so they can avoid collection action.
- 5) A service charge of \$35.00 for all returned checks will be assessed. If the balance due is not promptly resolved within 7 days of the returned check, collection action will be initiated. Patient will lose check-writing privileges in our practice.
- 6) For minor patients of divorced parents, the parent who initially brings the child in for treatment is considered to be financially responsible for our practice, regardless of the divorce decree. This office will not be caught in the middle of family financial disputes.
- 7) We request 2-business days notice for any change in your scheduled appointments. When you make an appointment, we reserve a treatment room, appropriate staff and equipment just for you. Canceling or missing appointments with short notice makes it impossible for us to offer your reserved appointment time to another patient. If insufficient notice is received, you will be charged a fee of \$35.00 per appointment.

**AGREEMENT:** I read, understand and accept the financial agreement outlined above. I understand that this agreement applies to all patients in my account.

**AUTHORIZATION:** I authorize Dr. Childers to submit claims for payment for services to my health care service plans, insurance companies, or other benefit programs on my behalf. I assign to Dr. Childers, insurance benefits otherwise payable to me. This financial agreement and authorization shall remain in effect as long as I receive dental services from this office.

**AGREED TO AND AUTHORIZED BY:**

Printed name of account guarantor/insured	Printed Name
Signature of account guarantor/insured	Date