Tina P. Moses, DMD, PC
Pediatric Dentistry

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Office Policy

Thank you for choosing us as your child's dental care provider. We consider it an honor, and we will strive to meet your expectations.

- We see patients by appointment only. If you cannot keep appointment or arrive on time, please give at least 24 hrs notice.
- Please prepare to pay for treatment at each appointment and pay the insurance deductibles/co-payments where applicable.
- Please bring the child's current insurance card to each visit. As a rule, insurance eligibility is verified prior to visit.
- At a maximum, please limit those accompanying patient to one adult and one other child. There is limited space for seating.
- Please control child/children's conduct in the waiting room as well as external premises of this office. Also, please supervise child's use of the rest room facilities. Destructive activity and annoyance to other patrons cannot be permitted.
- The employees of this office are carrying out the direction and policies of Dr. Moses. Should you find problems with these policies, or the attitude or conduct of our employees, please report this to Dr. Moses. On the other hand, parents or guardians who use abusive language, argue and otherwise fail to cooperate with our staff will be dismissed as patients.

Appointment Policy

- At least 24 hrs notice is needed for appointment rescheduling or cancellation. If not, a missed appointment fee **$40** is assigned.
- Three (3) missed/broken appointments will prevent further scheduling by this office.
- Late arrivals may not be seen, and should the child not be treated on date of appointment, it becomes a missed appointment.
- Children from the same family who have broken or missed appointments may not schedule together on the same day.
- There is a limited number of after school appointments. We ask for your cooperation when such time slots are not available.
- Patients who fail to come to their first appointment are not re-scheduled.

Financial Policy

We are committed to the successful treatment of your child. Please understand that payment of your bill is considered a part of this treatment. The following is a statement of our financial policy, which we require you to read prior to any treatment.

Payment in full is due at the time of service. We accept cash, checks, debit or credit cards through use of an automated system. As a courtesy to you, we will file your insurance claim (see insurance below). No payment plans are available through this office. A returned check fee of **$50.00** is enforced. A request for records release requires a written statement and a **$25** fee.

Missed Appointments: We value your patronage. However, we require that you honor your committed appointment. If you cannot attend a scheduled appointment, we require a 24 hour notice of cancellation. If no notice of cancellation is given, a **$40.00** fee is assigned. This amount varies depending on type of appointment such as consent, sedation or OR. This fee is not covered by insurance; it is solely your responsibility. If more than one child is scheduled for date of missed appointment, each child will be separately assigned a fee. Henceforth, children will be scheduled separately. Continued missed appointments/cancellations will result in your termination as patients.

Insurance: For the convenience of our patients, our office accepts assignment directly from your insurance company. You must be aware that this payment is not necessarily 100% of the charges. As a courtesy, we will bill your insurance company for treatment performed. **The patient or responsible party pays the co-payment and deductible at the time of treatment.** We will use your insurance company's benefit schedule to determine this amount. If an inaccuracy exists in payment, we will refund any overpayment. If your insurance company underpays, you are responsible for the account balance. **If patient is deemed ineligible for insurance coverage on date of service, the parent or guardian is solely responsible for payment.**

No insurance company covers 100% of all dental costs. It is your responsibility to insure that payment from the insurance company is made within 30 days of the date of service. After 30 days, if the insurance company has not paid claim, you will be given 30 days to pay the account balance in full. **After 60 days, the account will then be turned over to a collection agency**.

Payment for services is due in full at the time of treatment unless prior arrangements have been made.
If this account should go to collections, you will be responsible for all collection fees and any attorney fees.

Please remember that you are responsible for paying all fees for services rendered to your child.
Your insurance policy is a contract between you and your insurance company; we are not a party to that contract.
It is the insured's responsibility to correct any problem of payment with the insurance company.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area and for a pediatric specialty practice. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance plan. Examples often include oral sedation, analgesia, sealants, or behavior management.

Thank you for your cooperation.

Reference to "patient" responsibility is intended to directly refer to the adult legally responsible for the child being treated by this office.