As a pediatric dental practice, we offer services to children from birth through the teen years. We are excited to welcome your child as a new dental patient. Please read the information listed below carefully. This form is designed to assist you in understanding your financial responsibility and the methods of payment.

* A parent or legal guardian must accompany the child for the child’s initial visit. If someone other than the parent brings the child for subsequent treatment, we require a signed consent form for each visit. Arrangement for payment should be planned accordingly.
* Please be aware that the parent bringing the child to our office is legally responsible for payment of all services.
* Payment in full by cash, check or credit card is requested at each appointment as service is rendered. We accept American Express, Care Credit, Discover, Mastercard and Visa. A copy of your valid drivers’ license is required for identification purposes if paying by check or credit card.
* Dental insurance is meant to assist patients with payment for regular dental care. We require a copy of the policy holder’s dental insurance card along with their insurance identification number and social security number in order to have dental benefits assigned to our office. Even if you have insurance coverage, please realize that you are responsible for payment on your account. We will be happy to help you receive the maximum benefits available under your policy; however, the relationship is between you, the insured, your employer, and your insurance company. **We are not a party to the contract.**
* We attempt to provide the most accurate information available. Insurance companies will not guarantee their information so we regret that we can not be responsible for any discrepancies in benefits estimated. Information given to you by our office regarding your benefits is a courtesy. You, the policy holder, should verify and be knowledgeable about your insurance benefits.
* We ask that you pay the **estimated** difference between what your insurance covers and the actual charges incurred. If there is a balance owed after insurance benefits have been received, a statement will be sent to you. Payment is expected in full within 7 days of receiving the statement. After 30 days, a late fee of $10.00 will be added to your account each month until paid.
* If we do not receive payment from your insurance company after 60 days, you will be responsible for payment in full.
* We do not file claims with secondary or medical insurance. We will, however, provide you with a receipt of services to assist you in filing claims.
* We appreciate those patients who honor their scheduled appointments. **We do assess a $25.00 fee to those patients that cancel or break their appointment without 24 hours’ notice, as this time with the doctor has been reserved for you.**

Thank you for choosing our office for your child’s dental needs.

I UNDERSTAND AND ACCEPT THE FINANCIAL AGREEMENT OF THOMPSON RAY BOGERT, D.D.S. AND WILL ABIDE BY IT. ALL MY QUESTIONS REGARDING THIS AGREEMENT HAVE BEEN ADDRESSED AND ANSWERED.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_

Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_