THE
BEACH HOUSE
PEDIATRIC
DENTISTRY & ORTHODONTICS

Financial Policies

Name: ____

Payment for Professional Services
I, as the responsible party for the account, understand that payment for professional services received in this office is due and payable at the time of service. All arrangements must be made prior to the patient's appointment. This office does assess a late fee on all balances after 60 days until the account is paid in full.

Insurance Administration (if applicable)
I hereby agree to assign all insurance payments to The Beach House Pediatric Dentistry and Orthodontics. I also understand that The Beach House Pediatric Dentistry and Orthodontics is filing my insurance as a courtesy to me, but I am ultimately responsible for the payment of the account. I agree to pay any outstanding balance regardless of the cause within 45 days of treatment. I am also responsible for notifying the office when any changes occur to my dental benefits.

Appointment Cancellation Notification
I understand that The Beach House Pediatric Dentistry and Orthodontics reserves appointment times to provide my child with the individual attention he/she deserves. I agree to give notice of two business days if it is necessary to make a change in my child's scheduled time. I also understand that failure to give notice may result in a broken appointment fee.

Returned Check Fee
In the event my personal check is returned from my financial institution for any reason, I agree to pay a processing fee of $30 to The Beach House Pediatric Dentistry and Orthodontics.

Account Collection Fees
In the event of my default on financial obligations to The Beach House Pediatric Dentistry and Orthodontics, I agree to pay interest on the indebtedness together with any required collection fees.

________________________________ ______________________
Signature (Patient, Parent or Guardian) Date

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