Ponte Vedra Pediatric Dentistry & Orthodontics
Payment of Services Rendered

To avoid any misunderstanding regarding payment of services rendered and to facilitate the processing of your claim, we ask you to read and sign this agreement.

If you have dental insurance, we are happy to assist you with filing your dental insurance claim. In order to help us file your insurance, we ask you to complete the entire patient and insurance sections of your paperwork and provide us with your dental insurance card. If you are a self-pay patient, we do require payment in full on the date of service for all services provided.

As a courtesy to our patients with insurance, we will accept assignment of benefits directly from your primary insurance company to reduce your personal expense. Please understand that your insurance contract is between you and your insurance company and acceptance of direct assignment of benefits does not change that relationship.

We are always happy to provide you with a dental estimate for services upon request. Also, if dental treatment is needed, we will provide you with a treatment plan including an estimate of cost for any out of pocket and/or copays expected at the time of service. Please be aware this is simply an estimate and may not always be 100% accurate. We must, therefore, assume no liability to perform services for prices quoted in the original estimate.

I, the responsible party, understand and agree that I am responsible for the payment of all dental services provided for myself and/or my dependent. If my insurance fails to make payment, or denies payment for any reason, I am responsible for the full amount owed for all dental services provided. If I have any questions concerning explanation of benefits received or payments made by my insurance company, it is my responsibility to resolve these questions by contacting my insurance provider. I agree that I am responsible on the date of service for the estimated fees not paid by the insurance company and any balance if any thereafter a claim is satisfied.

I further agree that should it be necessary to pursue the collection process and/or legal action in recovery of any debt, I would be responsible for all collection and/or lawyer fees associated with the collection of any overdue balances. If this account is sent to collections, I will be charged additional collections fees of 40% of my account balance. In addition, there will be a $30.00 service fee charged by Ponte Vedra Pediatric Dentistry & Orthodontics. This fee if for the processing of all paperwork involved in sending this account to collections.

Fluoride Treatment: Our fluoride recommendations are based on guidelines established by the American Academy of Pediatric Dentistry and American Dental Association. All insurance companies pay for fluoride differently. Please be aware of your dental policy regarding how fluoride treatments are covered as it will be an included service at your child's regular dental check-up appointments.

If I have insurance coverage from more than one insurance company, I understand that this office does not file secondary insurance and I am fully responsible for filing my secondary insurance.

Name of Parent/Guardian/Responsible Party: _____

Signature of Parent/Guardian/Responsible Party: _____

Relationship to child: _____ Date: _____