Just4KidzDentistry
Celeste Wegrzyn, D.M.D., M.S.
1115 West Street, Suite 4
Southington, CT 06489
Phone: 860-426-1470
Fax: 860-426-1447
www.Just4KidzDentistry.com

Welcome to Just4KidzDentistry! We thank you for choosing us to care for your child. It is our primary goal and responsibility to provide children with the highest quality dental care. It is toward that goal that we wish to direct our time and energy. Therefore, we ask you to carefully review and sign our Financial Policy below. If you have any questions about our payment options, please do not hesitate to speak to a member of our team.

1. Patients with dental insurance must provide accurate and complete insurance information. We will be happy to file your insurance benefits and submit your claims as a courtesy to you. As the parent/legal guardian of:

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I authorize Just4KidzDentistry to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company on my behalf and in my name listed as "signature on file" providing assignment of insurance benefits to Just4KidzDentistry.

If insurance coverage cannot be verified, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.

2. Our relationship is with you and your child, not your dental insurance company. Your dental benefit is a contract between you, your employer and the insurance company. The percentage covered for each procedure is determined by how much your employer has paid for coverage and is not related to our professional fees. Our office does not determine your dental benefits. Most plans pay between 50-75% of the average total fee. This is how your co-payment is estimated.

3. Prior to completing any restorative treatment, we will provide you with a Treatment Plan which includes our total fee, your estimated insurance coverage, and your estimated out-of-pocket costs. Please remember, these are only estimates and may change during the course of treatment. Sometimes, treatment alternatives become necessary for various reasons, which may increase or decrease treatment costs. Further, most insurances do not tell us exactly what they will cover, so we are only giving you our best ESTIMATE. Some insurance companies do not reimburse dental offices directly. In these rare cases, you will be responsible for the full cost at the time services are provided and your insurance company will send you the reimbursement check directly.

4. Any amount not covered by your insurance company is payable at the time services are rendered. These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. For your convenience, we accept cash, checks, Visa, MasterCard, American Express and Discover. We also accept Flex Spending Cards. Any returned checks will incur a service charge. We cannot accept responsibility for negotiating a disputed claim and allow a maximum of 60 days for your insurance company to clear account balances. If your insurance company does not pay within 60 days of the treatment rendered, we shall expect payment in full from you.

5. Any remaining balance will be billed to you after a claim is paid. Any balance will be due upon receipt of your statement. A billing fee of $10 will be applied to all accounts unpaid over 60 days. In the event that this matter is turned over to an attorney or agency for collection, you will be responsible for all costs incurred in the collection of this debt. The parent or legal guardian who brings the child for the appointment is responsible for payment, regardless of who holds the insurance and independent of what a divorce decree may state. Reimbursement must be made between the divorced parents, we will not intervene.

6. Your child is unique and special to us, and appointment times are reserved exclusively for each patient. If you do need to change an appointment, we require you give us 2 working days' notice so that we may make the time slot available to another patient. We realize that unexpected things can happen, but ask for your assistance with this regard. A missed appointment fee of $50 may be applied to your account with less than 2 working days' notice of cancellation. Repeated failure to keep appointments without notice may result in our office discontinuing treatment for your child.

I have read and accept the above Financial Policy. I understand, acknowledge and agree I am fully responsible for the total payment of all procedures performed including treatment that is not a benefit of any dental insurance I may have.

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Print Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian	Date