Dermody Pediatric Dentistry & Orthodontics, P.A.
Financial Policy

772-562-5150
772-562-2711 (fax)
2000 35th Ave
Vero Beach, Florida 32960

This is an agreement between Dermody Pediatric Dentistry & Orthodontics, P.A., as creditor and the Patient/Debtor named on this form.

In this agreement the words "you" "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we" "us" and "our" refer to Dermody Pediatric Dentistry & Orthodontics, P.A.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, finance charges and any payments or credits applied to your account during the month.

Payment Options If You Have No Insurance:

A. You choose to pay by __cash __ check or __credit card on the day that treatment is rendered.
B. Any treatment involving laboratory fees (appliances) you may choose to pay 50% on the preparation date and the balance on day of deliverance.
C. On extensive treatment, you may prefer to secure a bank, credit union or other third-party financing for the entire amount and make payments to the lending institution.
D. We offer a 5% cash discount on treatment over $500.

Payment Options If You Have Insurance:

A. You choose to pay your deductible of $____ and any out-of-pocket portions at the time services are rendered by __ cash, __check or __credit card.
B. You choose to pay all of your treatment by __cash __ check or __ credit card. We will request your insurance carrier send their payment directly to you.
C. On extensive treatment (appliances) you may choose to pay 50% of your out-of -pocket portion on the start or preparation date and the balance on the completion or delivery date. (Normally 3 weeks later.)
D. If we cannot verify coverage before checkout, you will be responsible for that day's treatment.

Payments: Unless other arrangements are approved by us in writing, the balance of your statement is due and payable when the statement is issued and is past due if not paid by the end of the month.

Insurance: Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account, sixty(60) days if insurance is filed. The FINANCE CHARGE will be computed at the rate of 1.5% per month of an ANNUAL PERCENTAGE RATE of 18%. The finance charge on your account is computed by applying the periodic (1.5%) to the overdue balance of your account. The minimum finance charge is $50.

Credit History: You give us permission to answer any questions concerning your credit history with us. We also have your permission to check your credit and employment history. We have the option to report your account status to any credit reporting agency, such as a credit bureau.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement, therefore we cannot bill you for these.

Returned Checks: There is a fee (currently $25) for any checks returned by the bank.

Missed Appointment Fee: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a $20 fee. This fee must be paid before a new appointment is scheduled. If treatment scheduled is over $500 and you miss an appointment, you may be asked to pay ½ or all of the next visit up front before rescheduling. Patients who miss three appointments will be asked to transfer their records to another doctor. We ask that you be on time for your appointment. If you are late, you may be asked to reschedule. **If you need to cancel an appointment during non-business hours, please stay on the line and our answering service will assist you. You may call back during normal business hours to schedule a new appointment.**

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur, as well as all court costs. In case of suit, you agree the venue shall be in Indian River County, Vero Beach, Florida.

Waiver Of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce/separation remains responsible for the account. After a divorce/separation the parent authorizing treatment and bringing the child to the appointments will be the parent responsible for those subsequent charges. If the divorce decree requires the parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring Of Records: You will need to request in writing, if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records be transferred to us from another doctor or organization, you authorize us to receive all relevant information, including your payment history.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-Signature: If this or another financial policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name:_____

Responsible Party:_____
(if not the patient)

Signature:_____ Date:_____

Co-Signature:_____ Date:_____