Peninsula Children's Dentistry
Purvi Zavery, DDS, MS
Creating A Lifetime of Healthy Smiles!

Office and Financial Policy

Our primary goal and responsibility is to help our patients obtain good dental health and make you and your child's visit to our office a very positive experience. So that we can focus our time and energy on your child, we have prepared this letter to inform you of our office and financial policies.

Financial Policy

Payment is expected at the time of service. If you have insurance, you will be expected to make an estimated payment for that portion not covered by your insurance plan. We are sensitive to the fact that families have different needs in fulfilling their financial obligations, therefore, in addition to cash and check, we accept most major credit cards. If special arrangements are needed, please talk to our office prior to receiving service. A late charge of 1.5% per month or a minimum late charge of $10.00 will be added to balances over 60 days past due.

Dental Insurance

As a courtesy to our patients who have dental insurance we are happy to submit the necessary forms. Because insurance policies vary greatly, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. **Your estimated patient portion must be paid at the time of the service.**

It is important to remember that the policy is a contract between you and your insurance company. We will fully attempt to help you receive full insurance benefits; however, you are responsible for your account**. If your insurance policy does not pay within 60 days, you are responsible for the entire balance, paid-in-full. Please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.** For more information about insurance, please visit our website at www.PeninsulaKidsDDS.com

Appointments

When you make appointment with us we consider your time as "confirmed" or reserved. As a courtesy, we will be happy to call you prior to your visits to see if you have any questions regarding your appointment. Should a scheduling conflict arise, **please give our office at least 48 hours notice** so that we may reschedule you properly and you don't incur a cancellation fee.

I consent to Peninsula Children's Dentistry using my mobile phone number to ___ call and/or ___ text and receiving email communications regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My mobile # is _____ Initial: ____ My email is _____ Initial: ____

We sincerely thank you for your continued support and belief in our office. If you have any questions, our courteous staff is always available to answer them.

I have read the above, and I understand and agree to this office and financial policy.

_____ _____

Signature of Patient or Responsible Party Date