Children's Dentistry of Inland Empire
Office Policy

Dental Insurance

• We are dedicated to providing all our patients with the finest treatment available and base our treatment recommendations on what will be best for your child, not what your insurance company does/does not pay.
• Our relationship is with you and your child, not your dental insurance company. Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
• As a courtesy, we will verify your insurance eligibility prior to your child's appointment. However, **our office does not determine your dental benefits.** Knowledge of benefits, benefit amounts, co-pays, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility.
• We will gladly file your claims and accept assignment of dental benefits; however, you are responsible for all fees on your account.
• Based on the information your insurance company provides our office, we can only estimate your insurance benefits, we are not responsible for their accuracy and cannot guarantee payment from your insurance. All charges not paid by your insurance company are your responsibility, regardless of the reason for non-payment. Not all the services we provide are covered benefits. Benefits differ from one company to another.
• **Fees for non-covered services, deductibles, and co-payments, are due at the time services are rendered.**_____ (Initial)

PAYMENT POLICY

• We offer the following methods of payment: Cash, MasterCard, Visa, Discover, and Care Credit.
• After your dental insurance has paid its portion, a statement will be mailed to you for the remaining balance. Payment is expected within 30 days of the statement date.
• If the insurance company does not pay in full within 60 days of the claim date, you assume responsibility to pay the full balance within 20 Days of the statement date. _____ (Initial)

Broken Appointment Fee

• For patient's that need treatment, YOU must notify our office within 48 hours of your appointment if you need to reschedule or cancel your appointment if not you will be charged $40.00._____ (Initial)

OVERDUE BALANCE

• An account with a past due balance of 120 days, will be sent to collections. At that time, you will be responsible for any and all costs incurred in the collection of your debt: the unpaid balance, attorney fees, court fees, and any other fees associated with the collection of your debt. _____ (Initial)

***I have read, understand, and agree to the policies that have been outlined. I authorize dental treatment on my child and I take full responsibility for the account I have with Children's Dentistry of Inland Empire. I also authorize this office to bill my insurance for all agreed upon dental treatment and agree to pay all related professional fees.**

Child's Name:_____ **DOB:**_____
Parent/Guardian Name:_____ **Date:**_____
Signature:_____

8209 Rochester Ave #101 Rancho Cucamonga, CA 91730 (909) 484-9555 Fax (909) 484-9730