Print Form

LAKE HOUSTON PEDIATRIC DENTISTRY

Office Policies

Our office is committed to providing you with the highest quality dental care using only the best material and technology available. Our clinical and administrative teams work closely together to ensure a positive experience for children and their parents. Payment for services is expected at the time dental treatment is provided. Thank you!

Payment Options: We accept cash, checks, debit cards, Visa, American Express, MasterCard, Discover, and CareCredit. (Ask for details)

Financial Responsibility: The parent/guardian bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other people.

Statements: We will send a statement to the address on file if/when there is a balance due.

Past Due Accounts: The balance on your statement is due upon receipt. A $5 late fee charge may be assessed on any account that is not paid within 30 days. If necessary, accounts not paid within 60 days may be referred to a collection agency. All incurred expenses will be the account holder's responsibility.

Insurance: We accept all PPO plans but are a participating provider in the Delta Dental Premiere Plan ONLY. We work OUT OF NETWORK for all other insurance companies.
We are happy to file claims on primary PPO policies as a courtesy to our families. (We do not file claims on DMO policies.) Filing your insurance is NOT a guarantee of payment. Please be aware that the parent/guardian remains responsible for payment of any/all services rendered.
Our doctor will recommend services and treatment based on your child's needs, NOT on what your insurance will pay. Examples may include x-rays, fluoride and sedation. Please provide current insurance and contact information at time of service.
In the event that your insurance has not paid on your account within 60 days, the balance may be transferred to Patient Responsibility. We reserve the right to discontinue or decline to file a claim. Please remember that coverage is an agreement between YOU and YOUR insurance company. You should familiarize yourself with your benefits.

Required Payments: At treatment appointments, we collect a percentage of the total cost of treatment determined by an ESTIMATION of what your policy will cover. In the event your insurance underpays our estimate, we will send you a statement for payment in the mail. Conversely, if insurance overpays our estimate, you will be due a credit or refund.

Returned Checks: If your bank returns your check to us for any reason, a $30.00 fee will be charged to your account.

Appointment Policy
Children tend to have a better overall experience at the dental office when they are not tired. Therefore, we encourage morning appointments for pre-school age and nervous children. For many children, just a simple filling at the end of a long day can seem like a major ordeal. Please remember, one of our goals is providing dentistry that is as pleasant as possible for your child. Also keep in mind that a dental appointment is an excused absence from school.

When you schedule an appointment for your child, we are reserving time solely for your child and his/her needs. We do not double book our patients and we take pride in the fact that because we value your time, as much as we hope you value ours, we make every effort to see your child at the time scheduled. For this reason, it is very important that you arrive for your scheduled appointment on time. If you are late, it may be necessary to reschedule your child's visit.

Cancelling/Rescheduling: If you are unable to keep a scheduled appointment, a 48 hour notice is required. We understand that unforeseen emergencies do occur; however, we reserve the right to charge your account a $25 per person fee for repeated last minute cancellations or missed appointments.

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

I have read and agree to the above policies and understand my obligations to Lake Houston Pediatric Dentistry. I acknowledge that I am responsible for payment of any services not covered by my insurance plan.

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Parent/Guardian

_____

Date