MOUNTAINS EDGE
PEDIATRIC DENTISTRY

Financial/Insurance/Appointment Agreement

I authorize Mountain's Edge Pediatric Dentistry to release any information, including the diagnosis and records of any treatment or examination rendered to me or my dependents during the period of such dental care, to third party payers. I authorize and request my insurance company to pay directly to Mountain's Edge Pediatric Dentistry, dental insurance benefits otherwise payable to me.

Mountain's Edge Pediatric Dentistry only submits dental insurance claims, and only accepts insurance payments from dental insurance plans and companies. If you believe treatment or diagnosis should be billed to any other type of insurance, we will provide you with copies of the dental insurance forms enabling you to submit to the insurance of your choice. Payment from these claims will be sent to you. Additionally, payment for these services is to be paid at the time of service. Before submitting any insurance claim, please consult an attorney or insurance professional to avoid committing insurance fraud.

If the patient has two or more dental insurances, your account balance will be due after the primary insurance has been paid. The secondary dental insurance will reimburse the insured subscriber. I understand that I am financially responsible for all charges. According to Nevada State Law, all insurance claims are to be paid within 45 days of receipt of the insurance claim. I understand that any outstanding insurance balance that is due over 60 days will become my responsibility.

A parent or legal guardian (as determined by an Order of the Court) must accompany the patient to all appointments. Upon arrival please check in with the receptionist. A broken appointment is one that is canceled with less than 24 hours notice to the scheduled appointment time. Any appointment at which the patient, parent or legal guardian is not present, shall be considered a broken appointment. An arrival of 10 or more minutes past the beginning of the scheduled appointment time by the patient, parent, or legal guardian shall be considered a broken appointment.
I acknowledge there is a fee of $75 for each broken appointment.

Any unpaid balance due (as listed on a billing statement), not paid within 28 days of the monthly billing date, will be assessed a late charge of 1.5% each month. I realize that failure to keep this account current may result in my children being unable to receive additional dental services, with the exception of dental emergencies or when there is prepayment for additional services. In the default on payment of this account (payment due over 60 days), I agree to pay additional collection costs, postage, and attorney and court fees incurred in attempting to collect on this amount or any future outstanding balances.

Name of patient(s): _____

Name of Parent/Legal Guardian: _____

_____ _____
Signature Date