SUNSHINE PEDIATRIC DENTISTRY OF EVANSVILLE
701 N WEINBACH AVE, SUITE 910
EVANSVILLE, IN 47711

Patient Name:____**DOB:**____________________

- We appreciate the confidence you have shown us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.
- Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. **We expect these payments at time of service**. If your insurance carrier denies any part of your claim, or if you or your dentist elects to continue past your approved period, you will be responsible for your balance in full.
- The staff sends a pre-treatment estimate prior to operative appointments. It may take up to 3 to 4 weeks for the insurance company to respond. If the appointment takes place before the estimate arrives, 50% WILL BE DUE at the time that you schedule your appointment.
- The portion of work done that is not covered by your insurance **WILL be due BEFORE the appointment**. You will either be billed for the remaining balance (if more) or be refunded (if over paid).
- I have read and understood the above policy regarding my financial responsibility to Sunshine Pediatric Dentistry of Evansville services to the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. Any amount due after payment has been made by my insurance carrier I will be responsible for.
- Past due account balances will be turned over to a collection agency (Medical & Professional Collection Services). The parent/legal guardian/patient is responsible for all agency, attorney fees and/or court costs. In addition, I understand that if my account goes to a collection agency or placed with an attorney to obtain judgement or otherwise satisfy payment of my account, a collection equal to 33% of the unpaid balance will be added to my account. I agree to pay these fees.

Deductible/Co-Pay Policy

- Some dental insurance carriers require the patient to pay a deductible/co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay the deductible AND the portion that your insurance does not cover. Thank you for your cooperation in this matter.

Cancellation/No Show Policy

- We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to give a 48 hour notice if you are unable to make the appointment scheduled.
- Giving less than a 24 hour notice **WILL** result in a $35.00 missed appointment fee.
- I understand that if I no show for an appointment without calling I may be dismissed from the office. I also understand that if I miss two or more appointments without proper notice, then I may be dismissed from the office. The practice will notify you in writing, via mail, if you are dismissed from care.
- I understand that it is my responsibility to inform the office of any changes in my home address, telephone number or insurance information and to know when my scheduled appointments are. Our office APPRECIATES IT VERY MUCH when you confirm your appointments. 😊 Our office does make every effort to remind you of your appointments as a courtesy.
- I have read and understand the above information and I agree to the terms described:

Patient/Guarantor Signature:__________________________________Date:____________________