Our Financial Policy

KYLE RAYMOND D.D.S.
PEDIATRIC DENTISTRY

Thank you for choosing us as your health care provider. We are committed to making your treatment a success. Please understand that payment of your bill is considered part of your treatment. The following statement is our Financial Policy; all patients must complete this form and our health history/insurance before seeing the doctor.

FULL PAYMENT OR ANY CO-PAYMENTS ARE DUE AND MUST BE MADE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/AMERICAN EXPRESS CARDS.

Regarding Insurance: We accept assignment of insurance benefits. We will file a claim with your insurance company, and they will pay us directly. **Should there be any items not paid in full by your insurance carrier, the balance is your responsibility. We can only estimate what your insurance company will pay based on the coverage information they provide to us. Insurance companies will not guarantee payment amounts until a claim has been filed and paid, therefore we cannot guarantee payment amounts at the time of service. For this reason, you may owe additional fees even if you make a payment at the time of your visit.**

We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company: we are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be the responsibility of the patient or responsible party. **Please be aware that some, and perhaps all, of the services to be provided may be non-covered services, or subject to a deductible. It is your responsibility to determine this with your insurance company.**

Regarding insurance plans where we are a participating provider: all co-pays and deductibles are due at the time of service. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Dr. Kyle Raymond hereby discloses to all referred patients, of ownership to The Hospital at Westlake Medical Center.

Remaining balances: **The responsible party will be billed approximately 30 and 60 days for any un-paid balances. Upon non-payment within the 90th day, a demand letter will be sent by certified mail. If payment is not received the matter will be turned over to a debt collection service. Any collection or attorney fees will be added to the initial balance and will be the responsibility of the responsible party. All debts that are turned over to our collection agency will be subjected to an additional interest charge of 20%.**

*******Our Office Now Requires A Prepayment When Scheduling Any Treatment Appointment *******
Cancellation Policy: Fee $75.00 will be billed to you if you do not give at least 24 hour notice prior to c/a of your appointment.

I have read the Financial Policy. I understand and agree to this Financial Policy

X_____
Name of Patient(s) Date:

X_____
Signature of Responsible Party Date: