

KidSmiles Pediatric Dentistry  
Ann Azama, DDS, MS  
Dennis Wong, DDS

2674 Ocean Avenue  
San Francisco, Ca 94132  
(415) 681-5437

**FINANCIAL POLICY**

Payment in full is expected at the time of treatment. When this is not possible, financial arrangements must be made prior to treatment. Previous account balance must be cleared prior to any future dental appointments. For your convenience we accept VISA, MC and discover.

**DENTAL INSURANCE:**

Patients with dental insurance must provide accurate and complete insurance information for the assistance in completing dental claims properly. You will be required to pay your estimated portion the day of treatment. Remember that professional services are rendered and charged to the patient and not to the insurance company. Insurance reimbursement is a contract between you and your carrier. If your insurance does not pay within 60 days, we shall expect payment in full from you. We cannot accept responsibility for collection of insurance claims or for negotiating a disputed claim. Your eventual reimbursement will be determined by your insurance carrier. If you have any questions, we will assist you.

**FEES:**

Fees may be assessed for the following:

Broken appointment \$50	Late Cancellation (less than 24hours) \$50
Returned check \$15	Late Charge (outstanding balance)\$10 per month

**Financial Agreement**

I acknowledge that I have read and understand the financial policy above. I agree that I am responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges not covered by insurance.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

**Assignment and Release**

I, the undersigned, have insurance with \_\_\_\_\_

Name of Insurance Company

And assign directly to Dr. \_\_\_\_\_ all benefits, if any otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my submissions whether manual or electronic.

\_\_\_\_\_  
Signature of the insured/Guardian

\_\_\_\_\_  
Date

( Please print a copy for your records )