We Care for Kids Dental
General Dentistry for Children and Young Adults
Leslie A. Olton, DMD Michelle Daniels, DMD

Financial Policy/Dental Insurance/Cancellation Policy

Dental Insurance

We are pleased to participate with several insurance companies directly. Please verify with your dental insurance company that we are a participating provider for your plan. Deductibles and estimated co-payment are requested from you at each appointment as service is rendered. These are determined by your benefits with your plan, not our practice. Please understand that we will gladly submit your dental insurance claim to your insurance company as a courtesy to our patients. You are responsible for understanding your insurance policy and terms, as well as payment of any balances due that are not paid by your insurance company. Any disputes regarding payments remains between you and your insurance company.

Cancellation Policy

We ask for your utmost courtesy regarding your scheduled appointments. If you are unable to keep your child's appointment and you must cancel or reschedule, please notify our practice at least 24 hours prior to the appointment time. There is a $25 charge for all missed appointment (failure to show) or a $20 charge for any appointments cancelled within 24 hours of your scheduled appointment. We understand that unforeseen situations occur, including illness, however you will be responsible for the payment of the missed appointment. We will, of course, make exceptions if you are experiencing a true emergency.

Patient Refusal to Cooperate

We reserve the right to charge a behavior management fee for patients who are unwilling to cooperate for dental treatment despite our best efforts.

Financial Policy

Payment is due when services are rendered. We accept cash, personal checks, MasterCard and Visa. Checks that are returned to our office from the bank due to insufficient funds are subject to a returned check fee. Unanswered delinquent accounts may be sent to our collection agency. You will be responsible for any fees incurred from the collection agency during this process. I understand and agree that (regardless of my insurance plan or marital status), I am ultimately responsible for the balance on this account for any dental services provided.

I have read the above information, understand my obligations and agree to these policies.

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SIGNATURE of FINANCIALLY RESPONSIBLE PARTY PRINT NAME RELATIONSHIP TO PATIENT(S) DATE

Please list all children associated with your account:

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