



## **Office Policy**

Thank you for choosing Montclair Pediatric Dental Care (MPDC) as your Dental Home.

Please read our office policy then sign and date prior to any treatment.

### **Payments for Treatment Rendered**

In an effort to keep the focus on your oral health and not finances, payment is required at the time of dental care. If your account has an overdue balance, future treatment may be delayed until your balance has been paid in full. For your convenience we accept cash, debit cards, and all major credit cards.

### **Appointments**

At MPDC we reserve a specific time for each patient based on his or her individual needs and cooperation level. Children in pre-school and elementary grades are usually seen in the morning. Children with dental emergencies or extensive treatment needs are seen in the morning. After school appointments are reserved for middle and high school age patients. MPDC provides a school or summer camp excuse note from the American Academy of Pediatric Dentistry (AAPD).

Our staff makes every effort to stay on schedule so we ask that families arrive ten minutes prior to their scheduled appointment times. Early arrival gives time for any necessary paperwork you may need to complete or question you may have. For your convenience, all our office forms are available on our website for you to print and bring on the day of your child's appointment or email to our office before the appointment. We encourage you to visit our website frequently for updates and information.

### **Dental Insurance**

Most major insurance plans do not cover 100% of treatment fees and have a deductible, which must be satisfied before any insurance benefits can be received. Please keep in mind that insurance coverage is based on the contract you have with your employer not MPDC. In

most cases you will be charged the difference in our fee and what your insurance covers. We require that all deductibles, co-pays, and/or any percentage of the bill that the primary insurance carrier does not cover, be paid at the time of treatment. As long as we are provided with all of your dental insurance information, as a courtesy, our office is happy to help you understand your coverage.

MPDC is in network with the two plans: Delta Dental Premier and Cigna Dental PPO. As a courtesy to our patients we will submit to the following out-of-network dental plans: Aetna PPO, MetLife, Guardian PPO, United Healthcare PPO, United Condordia PPO, and Ameritas PPO. We also submit to Horizon Dental PPO, however, we require payment at the time care is rendered. Horizon reimburses you directly. We will not submit to any HMO or DMO plans, as they require you to go to their providers only.

If your insurance company has not paid your balance in full within 90 days, the balance will automatically be transferred to your account, and you will be responsible for the balance owed. This office cannot render services on the assumption that our fees will be paid by your insurance company.

MPDC is committed to access to care for all families. If you do not have dental insurance we offer an in-house discount plan for uninsured families. The annual enrollment fee is required at the time of registration.

### **Cancellations**

At MPDC we want to be able to provide appointments that are convenient to your family's schedule. We ask if you need to cancel or reschedule please inform us within 48 hours prior to your appointment. We do understand many times last minute emergencies or illness occur, however, repeated last minute cancellations and missed appointments may result in a non-refundable prepayment request to reserve future appointments or a \$50 cancellation fee. As a courtesy to our patients, our office makes confirmation calls, text reminders, or email prior to your appointment.

### **Default on Payment**

In the event of default on payment, the Parent/Guardian promises to pay a service fee in the amount of \$25 in addition to the balance owed.

PLEASE KEEP IN MIND OUR OFFICE POLICY APPLIES TO WHOEVER BRINGS THE CHILD IN FOR TREATMENT. WE DO NOT SEND TREATMENT SUMMARIES TO OTHERS OR OTHER PARENTS.

I have read, understand, and agree to the Montclair Pediatric Dental Care office policy.

**Patient Name:** \_\_\_\_\_

**Signature of Parent/Legal Guardian:** \_\_\_\_\_ **Date:** / /

**Print Parent/Legal Guardian Name:** \_\_\_\_\_