



Beaver Brook Complex | I465 State Highway 3I S. | Annandale, New Jersey 08801  
phone: (908) 735-6300 | fax: (908) 735-6335

## **POLICY REGARDING PAYMENT AND DENTAL INSURANCE**

Thank you for choosing our office for our child's dental treatment. At the time of your appointment, you **MUST** provide us with the following items for insurance to be submitted electronically:

- Dental (not medical) insurance card;
- Name, address, employer, insurance company phone number, group number, subscriber's ID number, and date of birth.

If the above items are not provided at the time service is rendered, we will expect payment in full. We gladly accept cash, personal checks, Visa, MasterCard, Discover and American Express.

If we receive your insurance information at time of appointment, we will file your claim for you. You must be familiar with your insurance benefits, as we will collect the estimated amount that insurance will not cover. By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance claims electronically, so your insurance company will receive each claim within days of treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 60 days, a finance charge of 1.5% will be added to your account each month until paid.

We are in network **ONLY** with Delta Dental Premier. However, this does not mean if you have Delta Dental Premier that they will fully cover services rendered. Coverage depends on the individual policy that you have with your insurance company. You will be responsible for any balance.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. There is NO direct relationship between our office and your insurance company. We are not responsible for how your insurance company handles its claims or which benefits are covered.

**IMPORTANT:** You are responsible for providing any updates to your insurance policy at time of service. Please provide us with any changes to your personal contact information such as phone, address, etc.

For detailed information, please visit our website at [clintonkidsdentist.com](http://clintonkidsdentist.com)

**I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT OF MY CHILD'S DENTAL SERVICES, INCLUDING CHARGES NOT COVERED BY MY INSURANCE COMPANY.**

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PARENT/GUARDIAN SIGNATURE

DATE