



STAGECOACH CHILDREN'S DENTAL CENTER

Keith M. Coe, D.D.S.

32931 Decker Prairie Road • Magnolia, TX 77355

phone (281) 259-5444 fax (281) 259-5425

FINANCIAL POLICY

Payment is expected at the time services are rendered. We accept cash, check, MasterCard and Visa. Any returned checks are subject to a \$30 processing fee. **Please be aware that the parent bringing the patient to our office is responsible for payment of all charges.** In certain instances, we may accept assignment of insurance benefits. You are responsible for determining what type of insurance you have (indemnity or "traditional" insurance, PPO, or DHMO) **prior to the first appointment.**

In the event that we agree to accept insurance assignment you must: 1. Pay the **estimated** difference between what your insurance covers and the actual charges incurred. 2. After insurance pays, you are responsible for any balance **in full** upon notification by our office. 3. If insurance payment is not received from your insurance company within four weeks of submission, you will be expected to pay for all dental services rendered. 4. We attempt to provide the most accurate information available. However, insurance carriers will not release their fee schedules so we regret that we can not be responsible for any discrepancies in benefits estimated. Information given to you by our office regarding your benefits is a courtesy; you should also verify and be knowledgeable about your insurance benefits. 5. Your insurance is a contract between you, your employer, and the insurance company. **We are not a party to that contract and will not get involved in problems arising between you and your insurance.**

I UNDERSTAND THE FINANCIAL/INSURANCE ASSIGNMENT POLICY OF STAGECOACH CHILDREN'S DENTAL CENTER AND HEREBY ASSIGN ALL DENTAL BENEFITS TO WHICH I AM ENTITLED TO SAID OFFICE. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THE ASSIGNMENT WILL BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT. I AGREE AND ACCEPT THE ABOVE POLICY AND WILL ABIDE BY SUCH. ALL MY QUESTIONS REGARDING THIS POLICY HAVE BEEN ANSWERED.

SIGNED _____

DATE _____