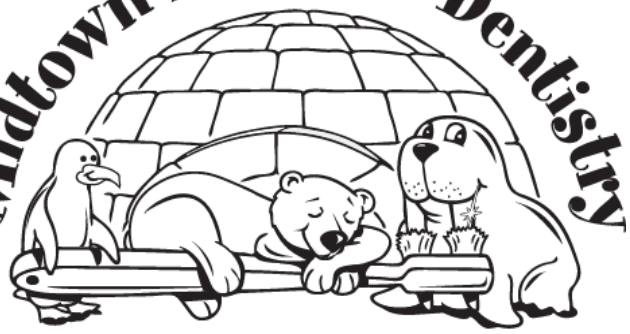
Midtown Pediatric Dentistry



DAVID C. SLAWINSKI, DDS, PA

Financial Policy

Thank you for selecting our office as your child's pediatric dental provider. The following is a statement of our financial policy which we ask that you read, understand, and sign prior to any treatment.

We are committed to providing your child with the best possible dental care and are happy to discuss our professional fees with you at anytime during our normal business hours. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your responsibility.

Payment is requested at each appointment as service is rendered and can be made by cash, check, MasterCard, or Visa. Please be aware that the parent bringing the child to the office is legally responsible for payments on all charges. We cannot send statements to other addresses.

Dental Insurance Information

(If Applicable)

As a courtesy to you, our patients, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. Note that some insurance companies will not allow assignment of benefits to our office, and will reimburse you directly. In those cases, we will request payment in full for treatment rendered. If the insurance allows reimbursement directly to our office, and there is still a balance, you will be billed for the remaining portion. Our office will verify your benefits prior to treatment whenever possible.

You, the parent, are responsible for your entire account balance. If, for some reason, your insurance company does not pay your claim, you are expected to pay the balance in full within 30 days of the date of treatment. If your insurance company becomes unduly difficult to deal with, we will ask that you proceed with whatever measures you deem appropriate to collect on your claim.

I authorize the release of any information concerning my child's health care, advice, and treatment provided for the purposes of evaluating and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that I am financially responsible for payments in full of all accounts.

Signature of Parent or Guardian: _____Date: _____