Fox Kids
DENTISTRY & ORTHODONTICS

Financial Agreement

For patients with dental insurance: We will be happy to bill your insurance company for services provided by our office. Insurance coverage varies from patient to patient, and you are responsible for knowing the exact benefits offered under your specific insurance plan, including patient deductibles, yearly limits, coverage of services, and exclusions.

If you need assistance understanding your dental insurance plan and coverage, please let our staff know, and we can contact your insurance company on your behalf.

You will be responsible for any co-payment or fees not estimated to be covered by insurance *at the time of service*.

For patients without dental insurance: Payment will be expected *in full at each appointment* (unless previous financial arrangements have been made).

Any patient account balances in excess of $300 may result in the inability to schedule future appointments until the balance is paid and could ultimately result from dismissal from our office.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one of more credit reporting services.

I understand that I am responsible for the payment of all fees for dental treatment for the patient named. I understand that I am responsible for any fee not covered by the patient's dental insurance.

Signature of parent/guardian: _____

Print name: _____

Child's name: _____ Date: _____

511 SW 10th Avenue, Suite 810 . Portland, OR 97205 . www.foxkidsdentistry.com
(503) 223-5039 office@foxkidsdentistry.com (503) 223-1123