WESTFIELD PEDIATRIC DENTAL GROUP

Kelly Walk, D.D.S.
NJ Specialty Permit #6244

Myra Tariq, D.M.D.
NJ Specialty Permit #07265

Timothy P. McCabe, D.M.D.
NJ Specialty Permit #3983

Julie Jong, D.M.D.
NJ Specialty Permit #5478

Maria Shin, D.D.S.
NJ Specialty Permit #5254

FINANCIAL POLICY

We are committed to providing your child with the best possible dental care. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. We will file all insurance claims for you with any carrier that we participate with. Out of pocket expenses are due at the time of visit.

Insurance:

A) Our office participates with the following dental insurance companies: United Concordia, Advantage Plus, National Fee for service Cigna DPPO and Delta Dental Premier.

B) Many OUT OF NETWORK benefits cover preventative service, cleaning and sealants at 80% to 100%. (Age limitations may apply) I will assume full financial responsibility for payment of services rendered.

C) As a courtesy we will submit to most major insurance companies but you may be using your OUT OF NETWORK benefits. As usual, your estimated portion will be expected at the time of service. Any fees not covered after insurance payment has been received will be billed.

D) If you have Horizon Blue Cross Blue Shield you will be using OUT OF NETWORK benefits. Some of these plans pay patients directly instead of paying the doctor's office. As a result, Westfield Pediatric Dental Group will submit to these policies as a courtesy but will collect full payment on date of service.

E) We accept all major credit cards, personal checks, cash, and Care Credit. (Ask us about this option)

F) I understand that if x-rays are taken at Westfield Pediatric Dental Group and insurance does not cover them for any reason I will assume full financial responsibility for payment of these x-rays.

G) I also understand if fluoride is given and insurance does not cover it for any reason I will assume full financial responsibility for payment of fluoride treatment.

H) Westfield Pediatric Dental Group cannot be aware of all the individual requirements and limitations of each insurance plan. Please contact your insurance for details regarding your coverage.

I) I will assume full responsibility for payment for each office visit. Payment must be made at the time of service.

- In cases of divorce and/or separation: It is the policy of Westfield Pediatric Dental Group that the parent accompanying the child for treatment is held responsible for all charges.
- Missed appointments/cancellation policy: After a patient's third missed appointment I agree to pay a $50.00 deposit toward the following appointment.
- Returned checks: I acknowledge a fee of $30.00 for any returned check and all future payments will be credit card or cash only.
- Cost of collections: If this account becomes delinquent, and if this account is signed to a collection agency or attorney for collection, this will result in a $30.00 additional cost. Further appointments will not be granted to patients who have accounts in arrears.

FD5/wpdgsilfinancialpolicy/cs

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SIGNATURE OF UNDERSTANDING

I have received the Westfield Pediatric Dental Group Financial Policy

Patient Name(s):_____ D.O.B:_____

_____ D.O.B:_____

_____ D.O.B:_____

_____
Parent/Guardian (Print Name)

_____ _____
Parent/Guardian Signature Date

Signature financial policy
FD5/update2023CS