**INNOVATIVE PEDIATRIC DENTISTRY, LLC.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

**Insurance Information**

Insurance Group/Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\**Please Note – The insurance policy holder is not automatically the Billing Guarantor. The parent/guardian present at the time of the visit is the Billing Guarantor.*

**Notice of Financial Responsibility**

**Divorce/Child Custody**

Innovative Pediatric Dentistry, LLC will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgement, or the like (the “Arrangements”). Since Innovative Pediatric Dentistry, LLC is not a party to these Arrangements, it is not obligated to the financial terms of the Arrangements.

In cases of child custody, the parent who presents their child (the “Presenting Parent”) for care and treatment at Innovative Pediatric Dentistry, LLC is responsible for the payment of co-pays, co-insurance, and deductibles at the time of the service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical/dental expenses. If the child is on the non-custodial or non-presenting parent’s insurance, Innovative Pediatric Dentistry, LLC will still collect the applicable co-pays, co-insurance, and deductibles at the time of service from the Presenting Parent. Upon request, Innovative Pediatric Dentistry. LLC will provide a duplicate copy of your receipt so that the presenting Parent or guardian can seek reimbursement when appropriate.

 **OVER**

**Billing Guarantor**

I understand that payment of all dental care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient’s account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Innovative Pediatric Dentistry, LLC to release any patient information to my insurance company upon request, and authorize payment directly to Innovative Pediatric Dentistry, LLC. A photocopy of this authorization shall be considered effective and valid as the original.

**Non-Covered Services**

I am aware that some services performed by Innovative Pediatric Dentistry, LLC may be considered “non-covered” by my insurance carrier and I am fully responsible for payment of these services.

[ ]  **I have read and understand the above statements. I agree to the provisions regarding financial responsibility and my responsibilities as the Billing Guarantor.**

Billing Guarantor Name (print) Date of Birth

Street Address City State Zip Code

Social Security Number Phone Number

I authorize Innovative Pediatric Dentistry, LLC to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Visa ☐MasterCard ☐Discover

Credit Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_

Name as it appears on the card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing Guarantor Signature Date**