Duxbury Children's Dentistry

Hospital Information & Dental Insurance Disclaimer (In Network)

I, _____(parent / *legal guardian*), **acknowledge that I have received hospital paperwork for** _____(*patient*) **who is scheduled on** ____ / ____ / ____.

There is a non-refundable $395.00 hospital fee that is not covered by insurance in order to schedule your child for an OR date. This fee covers any evaluations, follow-up visits, and any applicable operating room fees Duxbury Children's Dentistry incurs from the hospital. This fee does not apply to any co-pays, deductibles and/or balances.

Duxbury Children's Dentistry, LLC (Dr. Kierstin Kerr) is an **in network** provider for your dental insurance plan and any treatment will be covered at a contracted rate*. The office will submit dental insurance claims on your behalf as a courtesy. Your insurance carrier may pay less than the actual bill for services. An estimate of benefits is usually received within 3-4 weeks, however, if it is not received prior to your appointment it is your responsibility to check insurance coverage prior to any treatment. It is your responsibility to check with your insurance plan for remaining benefits.

Payment is due 2 weeks prior to your appointment on ____ / ____ / ____.
Any additional treatment cost will be due within 30 days of your hospital visit.

Your **medical** insurance should be verified by Franciscan Hospital and they will notify you of network status, approval of anesthesia and facility fees and any co-payments or deductibles, if applicable. It is your responsibility to check with Franciscan Hospital for any medical insurance coverage or questions at (617)254-3800 x1542.

***If we have not been able to obtain a complete treatment plan needed for an estimate of benefits due to the lack of radiographs and/or a thorough clinical examination at our office please note, a pre-treatment estimate of benefits from your insurance company may not be able to be provided ahead of time and additional treatment may be needed at the hospital that was unanticipated.**

A copy of your medical & dental insurance cards must be on file with our office. Please make sure we have your most up to date insurance information.

Dental Insurance Company: _____

Group # (if applicable):_____ Subscriber ID #:_____

Medical Insurance Company: _____

Group # (if applicable):_____ Subscriber ID #:_____

- ☐ **Check here if you have secondary dental insurance.** It is your responsibility to provide our office with all of your insurance information to ensure proper claim filing.
- ☐ **CHECK TO CONFIRM & SIGN BELOW: I understand and agree to all of the above.**

Patient Name: _____
Patient Signature: _____ Date: _____

We ask that you provide a credit card to keep securely on file with our office. By signing below you agree to authorize use of this credit card to cover any unanticipated treatment cost during your hospital visit. After your treatment is complete we will notify you of any additional treatment cost prior to charging the credit card below. Please let us know at that time if you would like to use another form of payment.

I, _____, authorize Duxbury Children's Dentistry to charge the following credit card for any applicable co-payments/ additional cost upon completion of treatment in the hospital.

CC#: _____ **CVV:** _____ **Exp Date:** ____ /_____ **Zip Code:** _____

Print Name: _____ **Signature:** _____ **Date:** ___ /___ /____

*Please be aware co-pays may differ with an in-network provider. Refer to our office OR fee form for out of pocket cost if no insurance coverage or benefits remaining.