Brea Schmidt, DDS
14 East 4th Street Spencer, IA 51301
(712) 580-3300

Financial Policy

Thank-you for choosing our office for your child's dental treatment. We are committed to the dental health of your child! Please understand that payment of your bill is considered a part of your child's treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any dental treatment.

- **Payment is expected in full for each appointment as services are rendered and must be made the same day as treatment.** We accept cash, checks, VISA, Discover, or Mastercard. Overdue balance is subject to a service charge of 1.5% per month.

- **Dental Insurance** – We are happy to file your insurance as a courtesy to you. Keep in mind your insurance policy is a contract between you and your insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. We will accept assignment of benefits from your insurance company; however, **you are responsible for the full balance including any amount that is not covered by your insurance company**. If the insurance company does not process the claim within 60 days of submission you will be responsible for the balance.

- Please be aware that the parent or adult accompanying the child to Schmidt Pediatric Dentistry is legally responsible for payment of all charges. We cannot send statements to other persons.

- Should you need to reschedule you child's appointment, we would appreciate a 48-hour advanced notice. We certainly understand that cancellations on short notice due to emergencies and last minute developments may arise and can happen to all of us. However, the lack of reasonable, advanced notice results in lost opportunities to serve others. Therefore, if a patient fails or cancels two (2) scheduled appointments without 48 hours advanced notice, we reserve the right to dismiss your family from our practice.

I have read and understand the foregoing Financial Policy. I understand and agree to this Financial Policy. I authorize Dr. Schmidt to release any information including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers. I authorize and request my insurance company to pay directly to Schmidt Pediatric Dentistry insurance benefits otherwise payable to me. I authorize and request Schmidt Pediatric Dentistry to use my signature on file for my signature on all dental insurance forms to expedite computer processing of my claims.