**Dr. Kamar Maria Baloul**

**55 Main Street Unit 3**

**Framingham, MA 01702**

**508. 875. 9600**

# *FINANCIAL ARRANGEMENT*

*Payments:* Payment is expected in full for each appointment as services are rendered. Payment options are cash, check or credit card (Visa, MasterCard, American Express). For financing larger treatments, we offer Springstone Financial.

*Dental Insurance*: Insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and /or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered", "denied" or" over UCR". We will file your **primary** dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions and provisions determined by your insurance company. You agree to pay your portion of the charges not covered by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will file pre-treatment estimate for recommended treatment when it is requested by you.

*Missed/Late Cancelled Appointment Fee*: Our office requires 24 hours notification if you are unable to keep your scheduled appointment. A fee of $25.00 will be charged to your account .

*Emergency/After Hours Appointment:* If your child is seen for an emergency visit after our regular business hours, an "after hours" fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time of service.

*Finance Charge:* A finance charge of $5.00 will be added to your account for any balance that remains unpaid after 30 days from the date of service. This charge will be assessed monthly, until the remaining balance is paid in full.

*Returned Checks*: There is a fee of $25.00 on any checks returned by the bank.

*Monthly Statement:* If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the account, finance charge,(if any) and any payment or credit applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment: We cannot send statements to other persons.

*Past Due Accounts*: If your account is past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay the collections costs which are incurred.

*Divorce:* In case of divorce or separation, the parent/guardian bringing the child to the office is financially responsible. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from that parent /guardian.

*Effective Date:* Once you have signed this agreement, you agree to all the terms and conditions herein and the agreement will be in full force and effect.

This agreement is between Kamar M. Baloul DMD, MS ( pediatric dentist), and the patient/parent/debtor named on this form.

In this agreement, the words "you", "your" and "yours" means the Patient/Debtor. The word "account", means the account that has been established in your name for your child to which charges are made and payment are credited. The words "we", "us" and "our" refer to Kamar M Baloul, DMD, MS

By executing this agreement, you are agreeing to pay for all services that are received.

_____ _____

Patient Name Date

_____ _____

Parent /Legal Guardian/Responsible Party Parent/Legal Guardian/Responsible Party

(print name) (signature)