CLAYTON KIDS
DENTISTRY

Shraddha P. Kolappa DDS, PA

Financial Agreement

I understand that my insurance policy is a contract between myself and the insurance company, and Clayton Kids Dentistry is not a party to that contract. I am responsible for unpaid balances and non-covered services, which may result in additional fees.

I am responsible for informing the office of all changes to my information and insurance prior to my appointments. Insurance must be in force and verifiable at time of treatment, and if I do not have insurance, I agree to pay in full at the time of the appointment.

Balances over 30 days may be subject to 2% late payment fee per month.

I hereby assign all insurance benefits for services rendered, otherwise payable to me, directly to Clayton Kids Dentistry from Medicaid or my private insurance. I authorize Clayton Kids Dentistry to release medical information to my insurance company, its agents or any third party for use in determining my benefits. If my account enters a delinquent status, I agree to pay all costs of collections including attorney fees and court fees, if applicable. If my account enters court collection status, I accept that I will no longer be a patient of record. I understand that the fee for a returned check is $35. Clayton Kids Dentistry will maintain patient records for a minimum of seven (7) years following the latest date of service, barring any exceptions where required extended retention may be required.

YOUR SIGNATURE BELOW CERTIFIES YOU HAVE READ< UNDERSTAND AND AGREE TO THE FINANCIAL AND OFFICE POLICY PROVISIONS STATED ABOVE.

_____	_____	_____
Print Name	Sign Name	Date