



Michael A. Shannon, D.D.S., M.S., Inc.
Pediatric Dentistry
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949-388-KIDS

Financial Responsibility

It is our policy to discuss our fees and financial arrangements open and honestly with you. Regardless of whether you have dental insurance or not, you are responsible for the full financial cost of dental treatment.

If you have dental insurance all deductibles, co-payments, and portions of your bill that insurance does not cover are due at the time of service performed unless financial arrangements have been previously made with our office. For your convenience, we gladly accept personal checks, and most major credit cards. We also offer dental financing through Care Credit

If you have dental insurance, every effort will be made to estimate the portion of the total cost that may be covered by your dental insurance plan. Our office will process an insurance claim for payment of dental treatment directly to us. You will then pay only your portion as discussed on your financial arrangement plans.

If we process your insurance claim, we will wait up to 30 days for payment from your insurance company. If we have not received payment, we will then bill you and have you contact your insurance company for payment of their portion to you. If we process your insurance claim and payment is denied or is less than our estimate of your coverage, you will be billed the remainder. Delinquent accounts will be charged a late fee of 1.5% per month. If you receive any communication from your insurance company about fees and / or dental services performed, please contact our office immediately.

When benefits are assigned directly to this office, if the insurance company sends a check to you in error, we will hold you responsible for immediate and complete reimbursement. If the insurance company has not paid the entire benefit available, we will hold you directly responsible for payment of the outstanding amount.

At any point during treatment, if the insurance company becomes uncooperative, we reserve the right to refuse to work with that insurance company and will look to you for payment of the remaining balance and you will have to settle with your insurance company.

If you do not have dental insurance, payment of all services are due at the time of service.

The mouth, gums, and teeth are constantly changing due to the progressive nature of dental disease. The actual costs of dental treatment may differ from the estimate due to our treatment of this progressive dental disease. In the event the actual costs of dental treatment differ from the estimated costs, you will be responsible for any additional cost. Every effort will be made to notify you if this occurs.

I certify that my child _____ is covered by _____ Insurance Co. and I assign all insurance benefits directly to Dr. Shannon and Michael A. Shannon D.D.S., M.S., Inc. I understand that I am responsible for payment of all services rendered and am also responsible for paying co-payments and deductibles that my insurance does not cover. I hereby authorize Dr. Shannon to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I assume financial responsibility for the above named child. I understand that payment is due on the day services are rendered. I authorize Michael A. Shannon, D.D.S., M.S., Inc. Pediatric Dentistry to collect payment from the insurance company. I understand that the insurance company may pay only a portion of my bill and that ultimately I am responsible for the full payment.

Thank you for selecting our office. We hope that should you have any questions regarding finances, financial arrangements, or dental insurance, you will feel free to talk to us at any time.

Patient's Name / Responsible Party Name

Relationship to patient

Responsible Party Signature / Date

