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Pediatric Dentistry

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General Dentistry

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FINANCIAL POLICIES AND OPTIONS

We have several financial policy options available for your convenience in receiving the proper dental care. We have found that our patients appreciate knowing exactly what dental financial responsibilities they will incur. Therefore, we inform our patients about our financial policies before we begin treatment. Knowing this ahead of time allows us all to arrange for the completion of the necessary dental treatment.

1. **Dental Insurance**

Most insurance companies will not cover 100% of all dental expenses. Your portion, not covered by insurance is due at the time treatment is performed.

Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist. The patient is still the responsible party regarding the dental fees. We will be glad to process your insurance forms at no charge.

If your insurance company fails to pay your account within forty-five (45) days, payment will be requested from the patient or responsible party.

2. **Cash or Check**

Payment in full is due when services are performed.

3. **Credit Cards**

We accept Visa, Mastercard, Discover, and American Express.

4. **Gradual Treatment Plan**

If it will be easier financially for those patients without dental insurance, we can plan the completion of your dental work by spreading your appointments over several months or years. We will arrange to do the more urgent services at the beginning of treatment.

5. **Cash Discount**

A 10% discount will be given on treatment plans exceeding \$1,000 which are paid in advance.,

6. **Broken Appointments**

We expect 24-hour notice for cancellations. A broken appointment fee of \$50 will be assessed if no notice is given.

I understand Kids Little Smiles financial policies and agree to the above arrangements.

I _____, acknowledge that all expenses incurred with Kids Little Smiles are my debt. I am aware of my responsibilities for this debt minus all insurance payments that may be applicable. I am further aware that this debt may be increased by collection fees, if I fail to remit payment on monies owned. Should this account be referred to an agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All past due accounts over 45 days will be charged 1.5% interest on the unpaid balance per month.

Signed: _____ Date: _____