Sachin S. Parulkar, D.D.S., L.L.C.
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Delaware, Ohio 43015

Delaware
PEDIATRIC DENTISTRY

(740) 657-1562
(740) 657- 1628 Fax
www.delawarekidsdentist.com

Practice Financial Policy

We are committed to providing your child with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial and insurance policies is important to our professional relationship.

- All patients must complete and sign the Patient Registration and History form before seeing the Doctor.
- Full payment is due at the time of the service unless other arrangements are made.
- Twenty-four hour notice is required when re-scheduling or canceling appointments. A cancellation fee of $25.00 may be assessed for broken appointments with less than 24 hour notice.
- For your convenience, we accept Cash, Personal Checks, ATM Debit Payments, Visa, Master Card and Discover.
- A $25.00 service fee will be assessed to any cancelled or returned checks.
- You understand that if you begin major treatment that involves lab work, you will be responsible for the fee at that time.
- If sent to collections, you understand that it is your full financial responsibility to pay all court costs and all collection fees and/or attorneys fees.
- Treatment plans may change, and you will be responsible for the work actually done.
- In accordance to Ohio law 3701.741, we reserve the right to charge $2.74 for the first ten pages of requested medical records, and $0.57/per page for pages eleven thru fifty when requested by the patient or patient's representative. Records requested by any other parties are subject to a $16.84 initial fee, as well as $1.11 for the first ten pages, and $0.57/per page for pages eleven thru fifty. In regards to digital x-rays, charges are $1.87 per page.
- For your convenience, this office may release your information to your insurance company, and receive payment directly from them. Every effort will be made to help you with your insurance, however, the insurance company, not our office, determines the dental benefits that you will receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges are your responsibility. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.

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Name of Patient Patient's date of birth

_____ _____

Signature of Parent, Guardian or Personal Representative Date