Pediatric Dental Care of Wilmington
213 Main Street
Wilmington, MA 01887
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New Patient Financial Options

Dr. Gabrilowitz and her team would like to welcome you to the practice. We are committed to providing the best dental care for your child needs. We will, however, only be able to accomplish this by spending the time necessary to diagnose and treat their dental needs. This treatment is very important to for health and should not be postponed by financial concerns.

Patients under the age of 18 must be accompanied by a parent or legal guardian. It is necessary for the parent or guardian to give permission for treatment and to sign off on the medical history of the patient. The parent or legal guardian who accompanies the child to the office is responsible for payment of the fee.

To enable you to proceed without delay, our office offers several financial options. We encourage you to select a financial arrangement that works best in your budget. For your convenience, we offer the following financial arrangements when the total cost of your treatment exceeds $500.00**. (Fees less than $500.00 are to be paid at the time of service.)** Our philosophy is to make dentistry affordable to everyone and we hope this helps you to make us your child's dental home.

1. A **5%** immediate pre-payment courtesy will be given when treatment is paid in full by cash or check *3 working days prior to beginning treatment*.**
2. A **3%** immediate prepayment courtesy will be given when treatment is paid in full by credit card *three days prior to beginning treatment.***
3. We accept Visa, Master Card, American Express and Discover.
4. Our patients with insurance coverage are expected to pay our office directly for services rendered. As a courtesy we will file your primary insurance. Your insurance benefit will be paid by your insurance company directly to you.*
5. Patients wishing their insurance benefit to be sent to our office will pay their co-payment and deductible at the time of service and complete a credit card authorization form to be used only if their benefit plan does not pay the remaining balance in full or make payment of any kind within 60 days of completed treatment. *
6. The fee for treatment over $500.00 may be paid in monthly installments through Care Credit plan, upon credit approval.

- Number 1 and 2 are not available if we are a provider of your dental plan.
- This office will only assist patients with their primary insurance reimbursement. Additional plans must be filed separately with reimbursement assigned to the insured.

DENTAL INSURANCE:
I understand my dental insurance is a contract between the insurance carrier and myself, not between Dr. Gabrilowitz and the insurance carrier. As such, I understand that I am responsible for the full amount of all fees incurred for dental treatment. Any payments received by Dr. Gabrilowitz from my insurance carrier will be credited to my account or refunded to me if I have paid the fees incurred.

FINANCIAL RESPONSIBILITY:
I/We agree and personally guarantee, in consideration of services and materials provided by Dr Gabrilowitz to be responsible for payment in full of all dental fees. In the event that this matter is turned over to a collection agency, I/We agree that I/We shall pay all costs incurred in the collection of this debt.

Patient's Name (print)

Parent or Legal Guardian Signature Date