PLATTE CANYON
DENTAL

FINANCIAL AGREEMENT

We, the staff of Platte Canyon Dental thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and we believe that a high level of communication and cooperation will allow us to continue to provide quality service to all our valued patients. Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service. We make payment as convenient as possible by accepting (cash, money order, all major credit cards, Care Credit, and in-state checks). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Interest:

For any outstanding balances over 31 days, Interest of 5% will incur if a balance remains unpaid.

Insurance:

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. Please be familiar with your insurance benefits, as we will collect from you the estimated amount insurance does not cover. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and to notify our office of any information changes when they occur. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and if we are not contracted with your carrier, we will not negotiate reduced fees with your carrier. By law, your insurance company is required to pay each claim

within 30 days of receipt. We file electronically, so they will receive each claim quickly. You are responsible for any unpaid balance after 31 days whether insurance has paid or not. Balances unpaid after 31 days will incur a fee of 5% per month until paid. We would like to avoid this and will gladly send a refund to you if your insurance pays us.

Missed Appointments:

We require notice of rescheduling/cancellations 2 business days in advance. This allows us to offer the appointment to another patient. **If you fail to keep your appointments without notifying us in advance or are late to your appointment by more than 15 minutes: a missed appointment fee will incur.** This fee is **$75 per hour** scheduled in our office. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Initial: _____

Appointment Deposits: *Only applies to habitual cancellations.

For procedures scheduled for 2 hours or more, a non-refundable deposit of $100 is required at the time of booking for all services. This deposit confirms your appointment and goes towards your service. The remaining balance is due at the end of your appointment. Initial: _____

Timeliness of Appointments:

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to Platte Canyon Dental whenever applicable. I also agree, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for the costs of collections if such action becomes necessary.

Date: _____

Signature of Insured/Authorized Representative: _____

Signature of Witness: _____