PLATTE CANYON
DENTAL

FINANCIAL AGREEMENT

We, the staff of Platte Canyon Dental Care 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 of 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

Interest of 1.5% will incur if a balance remains unpaid after 60 days.

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. 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 referral information and to notify our office of any information changes when they occur. Even a pre authorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. 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.

Missed Appointments

We require notice of cancellations **48 hours 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 apply. 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

For procedures scheduled 2 hours or more a deposit of $100 applicable to the final bill or a credit card on file may be required.

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 Care whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Date: _____

Signature of Insured/Authorized Representative: _____

Printed Name: _____

Signature of Witness: _____