DENTAL BY NATURE

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Tel: (303) 776-6021

FINANCIAL POLICY

We are glad you have entrusted our office with your dental health. To provide you with quality, timely care, our patients need to understand our financial policy.

Statements: Statements showing all procedures including any procedures that your insurance company normally covers at 100% are sent monthly, or as Benefit Statements are processed. Please note your outstanding balance is due upon receipt of your statement, if payment is not received by the 20th of each month following the first billing cycle, there will be a late charge of $5.00 or 5% of the minimum payment, whichever is greater. If there is a balance on your account after 60 days, we will charge your account at a periodic rate of 1.25% per month (ANNUAL PERCENTAGE RATE OF 15%). AAA Health Centered Dentistry is a participating provider with Care Credit. Monthly payment plans are available with Care Credit, upon approval by Care Credit. Please ask our staff if you are interested in more information.

Non-Insurance: Payment is due at the time of service, unless financial arrangements are made with the office personnel. Noninsured patients are eligible for a 5% discount on any services over $500.00, if paid in full at the time of service.

Insurance: We encourage you to become familiar with your policy's exclusions, deductibles and required co-payments. As a courtesy to our patients, we will provide the processing of your **primary coverage** insurance claims. Insurance is a contract between you and your insurance company. We are not a party to this contract. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits and eligibility. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient/responsible party and that he or she is personally responsible for payment of all dental services. We cannot bill your insurance company unless you give us your insurance information. At your first visit if we do not have the insurance information, we will give you a statement to submit to your insurance company and payment will be required at the time of service. **All estimated co-pays, deductibles and non-covered portions of dental procedures are due at the time of service. If your insurance has not paid within 60 days, all charges will need to be paid by the patient or responsible party. Secondary insurance claims are the responsibility of the patient or responsible party.**

Missed Appointment Fee: Missed appointments are (at our discretion) charged at the rate of **$50.00.** Missed appointments are not only an inconvenience to our office but also do not allow other patients the opportunity to fill the appointment, therefore; Patients with 3 missed appointments may be asked to transfer their records to another doctor.

Late Cancellations: 48 hour notice is required for appointment cancellation. Late cancelled appointments are not only an inconvenience to our office but also, may not allow other patients the opportunity to fill the appointed time. Patients with a pattern of Late Cancellations may (at our discretion) be charged a **$50.00** missed appointment fee, and if the pattern continues may be asked to transfer their records to another doctor.

Past Due Accounts: Necessary steps will be taken to collect this debt; you are responsible for all costs incurred to collect the debt.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Workers Compensation: Written approval/authorization by your employer and/or worker's compensation carrier is required prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Returned Checks: There is a **$25.00** charge for each returned check.

Effective Date: Once signed, you agree to all of the terms and conditions contained herein.

Release: I hereby authorize Dental By Nature to release information to my insurance company, to the extent of facilitating payment of claims incurred with this office. I further authorize payment directly to Dental By Nature insurance benefits otherwise payable to me.

Patient's Name: _____ **Date:** _____

Responsible Party's Signature: _____

Relationship to Patient: _____