Alpine Dental Center

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. As a condition of your treatment, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

ALL EMERGENCY DENTAL SERVIES, OR ANY DENTAL SERVICES PERFORMED WITHOUT PREVIOUS FINANCIAL ARRANGEMENTS, MUST BE PAID FOR IN FULL AT THE TIME SERVICES ARE PERFORMED. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER.

DISCOUNTS (SENIOR, COURTESY) WILL APPLY ONLY IF FEES ARE PAID AT THE TIME OF SERVICE.

EXTENDED PAYMENT PLANS ARE OFFERED THROUGH CAPITAL ONE HEALTHCARE FINANCE-PLEASE ASK FOR DETAILS.

A SERVICE CHARGE OF 1.5% PER MONTH (18% PER ANNUM) ON THE UNPAID BALANCE WILL BE CHARGED ON ALL ACCOUNTS EXCEEDING 60 DAYS.

REGARDING INSURANCE

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patient is aware he or she is responsible for any services or amounts not covered under the terms their policy.

(over)

MINOR PATIENTS

Unaccompanied minors cannot be treated without signed consent and prior financial arrangements.

MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, a charge of $60 per hour of reserved time may be added to your account. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

___________________________Date:________ Relationship to Patient____________
Signature of patient, parent or guardian

___________________________Date:________ Relationship to Patient____________
Signature of guarantor of payment/responsible party