OUR FINANCIAL POLICY

Thank you for choosing us for your dental care. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we ask that you read and sign prior to any treatment.

ALL FEES ARE PAYABLE ON THE DAY SERVICE IS RENDERED. WE ACCEPT CASH, CHECKS, VISA AND MASTER CARD. If payment is not received, there will be a late charge of 1 ½ % added to the monthly balance (18% annually). There is a $20.00 service charge for all returned checks. In the event of default, the entire balance will be due and payable immediately, and if assigned to collection agency the patient will also pay 30% of the unpaid balance as the reasonable cost of collection. In the event an attorney is required to collect payment, the laws of the court of Colorado will have jurisdiction, and the patient will be responsible for all reasonable and necessary costs and attorney fees.

REGARDING INSURANCE: As a courtesy to our patients we will gladly file your insurance claim forms. However, it should be understood that you are responsible for your bill regardless of the status of your insurance claim. You are responsible for filing any secondary insurance. You are also responsible for any co-payments, deductibles or overages not covered by your insurance. If your insurance company has not paid your claim in full within 45 days, the balance will be automatically transferred to your personal account. If you have changed insurance companies and do not notify us immediately, you will be responsible for payment of services. We can then file your new insurance for you and have the payment sent directly to you. Please check your monthly statements regarding the status of your claim to insure that it is paid in a timely fashion and contact your insurance company if necessary.

Patient Name (Please Print) _____

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Signature of Patient, Parent or Guardian Date:

Relationship to patient:_____