PATIENT FINANCIAL OPTIONS

Our office is committed to providing you with exceptional quality dental care at affordable fees with comfortable financial options. It is our intent to ensure that you have every opportunity to wisely invest in a smile that will be beautiful, healthy and functional. For this reason, we have developed the following financial options, which we believe will be of great assistance to you:

PAYMENT IN FULL: For non-insurance patients, PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE. We accept cash, personal checks, Visa, MasterCard or Discover. Insurance patients are required to pay the portion of the bill we anticipate the insurance will not cover.

CARE CREDIT: Receive up to 12 months interest free by applying for this medical credit card.

DENTAL INSURANCE: As a courtesy to you, we will bill your insurance company. Remember, your insurance policy is a contract between you and your insurance carrier. We are not party to the contract. Please be aware that some, and perhaps all of the services provided may be non-covered. To avoid misunderstandings with regard to your benefits we suggest that you review your policy manual, or call the telephone number located on the back of you dental insurance card for an overview of benefits. Our financial coordinator at the front desk can also be of assistance. Remember, this office cannot accept responsibility for collecting your insurance claim for you or negotiating a settlement on a disputed claim. It is understood that you will be responsible for payment in full of all claims submitted to your insurance company that remain unpaid within 45 days from the date of treatment. The remaining balance owing on your account after your insurance settles is due within 10 days of the insurance payment, unless prior arrangements have been made.

FINANCIAL CHARGE: Payment for my bill is my legal obligation. In the case that my account should become delinquent and is placed in the hands of an attorney for collection, I agree to pay a one time $20 set up fee and attorney fees of 33-1/3% of the unpaid balance and interest owing plus all court costs and interest at a rate of 1.5% per month or 18% APR beginning 60 days after balance has become payable. In case of suit, you agree the venue shall be in Canyon County, Idaho. I also understand and agree that I am responsible for services rendered to my spouse or children.

WAIVER OF CONFIDENTIALITY: It is understood that if my account is submitted to an attorney or collection agency; if we have to litigate in court, or if past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

REQUIRED PAYMENTS: Any co-payment or deductible required by an insurance company must be paid at the time of service, this is an insurance requirement, we cannot bill you for this.

RETURNED CHECKS: There is a fee (currently $25) for any checks returned by the bank.

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MISSED APPOINTMENT FEE: Patients who do not show up on time for an appointment or cancel with less than 24 hours notice will be charged a $25 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

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 a 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 parents' responsibility to collect from the other parent.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Canyon County, Idaho.

BANKRUPTCY: I warrant that I am not a debtor under any proceedings in bankruptcy and have no intention to file a petition for relief under any chapter of the U.S. Bankruptcy code. I understand that where appropriate, credit bureau reports may be obtained.

TRANSFERRING OF RECORDS: A request must be made in writing, and a fee may be required if you would like to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

WORKERS COMPENSATION: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

PERSONAL INJURY: If you are being treated as part of a personal injury lawsuit or claim, we require verification for your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to personal injury case.

RELEASE OF BENEFITS AND INFORMATION: I authorize my insurance benefits to be paid directly to the doctor. I also authorize the doctor or insurance company to release any information required for this claim.

I HAVE READ THE ABOVE CONSENT TO TREATMENT AND PAYMENT AND AGREE TO THE CONTENT.

NAME: _____ DATE: _____

Gentle DENTAL CARE