COLBY PACIFIC
FAMILY DENTISTRY

- Patient Financial Policy -

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In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options.

1. Cash, Check or Debit Card
2. Visa, MasterCard and Discover Card
3. Payment plans are available through CareCredit or Lending Club (0% options available)

As a courtesy, we will process your insurance benefits in our office. We do our best to be well informed with your insurance plan specifics and processing. However, the contract is between you and your insurance carrier. Contacting your insurance carrier regarding dental benenfits with your questions or concerns is encouraged.

I agree that I am fully responsible for the total payment of all procedures performed in this office, this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within sixty (60) days of date of service, regardless of whether or not my insurance benefits have been received. .75% per month interest (nine percent (9%) per year) will be charged on accounts 60 days from treatment date.
*If insurance remits a payment after a payment has been paid by patient, credit balances will be addressed.

Please make your questions and concerns known to our Accounts Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Signature (responsible party) Date