BLACK HILLS AREA DENTAL

FAMILY FRIENDLY PRACTICE

Financial/ Appointment Policy

We value you as a patient and are committed to providing you with the best possible dental care. We want you to have a complete understanding of your **financial responsibilities** for the services to be provided. To assist us in achieving these goals, we ask that you review our financial policy.

Payment Method

Notice: **Payment is due at the time of service. Please choose the method of payment below.**

X **Payment in FULL** (circle One) **CASH CHECK CREDIT CARD CARE CREDIT**

INSURANCE ACCOUNTS: Please remember that your insurance is a contract between you and your insurance company and/or employer. Our dental practice is not a party to the contract. We recommend that any questions regarding the amount of coverage for the specific treatment be discussed directly with your insurance company or your employer.

If you have dental insurance you must provide us with the proper information, so a claim can be filed for you. Your insurance benefits will be assigned to our office. **If there is an outstanding balance after the insurance check has been received, you have the option of putting the balance on a flex credit card, Visa, Discover, or Mastercard. By signing this form you give us authorization to put the balance of your account after insurance pays onto your credit card of choice.** If you choose not to go with the credit card option, a statement will be sent to you and the remaining balance will be due within 30 days. **Over the 30 days a FINANCE CHARGE of 1.67%** will be computed on any balance. **The maximum ANNUAL PERCENTAGE RATE IS 20.04%.**

*If your check is dishonored or returned for any reason, you expressly authorize our office to electronically debit your bank account for the amount of the check, plus **$30.00 processing fee**. Your use of a check for payment is your acceptance of this agreement and its terms.*

FAILURE TO PAY: If at any time a scheduled payment is late or missed, this office reserves the right to call for immediate payment in full. If our attempts to collect your balance owed are unsuccessful your account will be turned over to an outside collection service and you will be responsible for all costs associated with collection of this balance. **Patient initials** X_____

If your insurance company has not paid the full balance of the claim within 45 days from the treatment date, you will be responsible for paying the balance.

APPOINTMENT FAILURE POLICY: We require at least **48** hour notice for cancelled appointments. If you fail to appear for your appointment we may be forced to dismiss you from our office.

CANCELLATION/DISMISSAL POLICY: Due to high patient volume, it is the policy of Black Hills Area Dental that upon three missed scheduled appointments, we will discontinue treatment for you as a patient in our dental clinic. We will treat you in emergency situations for a period of two weeks following the date of your last missed appointment to allow you adequate time to find a dentist. **Our office will be happy to transfer your records upon your request for a fee of $20.00. Patient Initials** X_____

I have read and understand the financial policy and missed/broken appointment policy of this practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient/Parent/Guradian X_____ **Date**_____