Salmon Dental Center
Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment. We are happy to address any concerns you may have, so please don't hesitate to ask.

Please note: Payment in full or insurance co-payment is due at the time service is provided. Our office accepts cash, personal checks, Visa, MasterCard, and Discover. Financing through CareCredit, a third party is available upon request and approval on qualifying purchases.

Additional fees will be applied for returned checks. All account balances over 45 days are subject to a late fee.

Payment Options:

1. **Cash Payments** including personal checks and money orders are accepted. We offer a **5% pre-payment courtesy** for payment in full upon scheduling for patients without insurance.
2. **Visa, MasterCard, Discover Card** and **Debit Cards** are accepted. We offer a **2% pre-payment courtesy** for payment in full upon scheduling for patients without insurance.

Do you have insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. Any non-covered services are your responsibility of the patient or guardian and must be paid in full. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express and CareCredit at the time we provide the service to you.

- Insurance payments are ordinarily received within 30 days from the time of filing a claim. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected.

- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Regular Visits: Our office practices *The Universal Standard of Care* which includes Comprehensive Examinations, Radiographs, and Hygiene care. Regular, follow-up preventive care is very important in maintaining long lasting dental health. Therefore, we encourage our patients to adhere to the recommended visits. We will advise you when it is time for your next visit and help you with appointments that best suit you and your busy schedule. **Emergency visits will be limited to two consecutive appointments when the recommended standard of care is not followed.**

Appointments/Cancellations: We are able to see our patients on an appointment basis, with the exception of emergencies. We consider an appointment made to be an agreement and commitment between our office and our patients. We rely on our patients to abide by that agreement. Therefore, if you are not able to keep an appointment, barring an emergency, please notify our office **at least 2 business days before** so that we may help you with another appointment and to fill our reserved time with another patient in need.

Consent: I, _____, have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient/Parent signature: _____ **Date: _____**

Staff Member signature: _____ **Date: _____**

Patient/Parent name: _____ **Date of Birth: _____**
Patient/Parent name: _____ **Date of Birth: _____**
Dependents: _____ **Date of Birth: _____**
_____ **Date of Birth: _____**
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