FINANCIAL & APPOINTMENT POLICIES

As outlined in our mission statement, we are committed to providing the very best care for your child. Part of the process of providing this care involves a financial relationship between you, the parent(s) and/or guardian(s) of your child, and us, the dental health care provider. In an effort to make your visit with us as comfortable as possible, we have provided for you, prior to your first visit, a description of our financial policy. Please take the time to review our financial policy below and gain an understanding of your financial obligation to your child's dental health care. If you should have any questions, please ask the front office team member.

As a condition of providing care for your child by this office, all fees must be paid at the time the care is provided. Payment for our services may be in the form of cash, check, MasterCard, Visa, American Express or Discover. We also accept CareCredit (a medical/dental credit card).

For our patients with dental insurance, we will be happy to file a claim for you if we have received all of your insurance information on the day of the appointment. On your first visit to our office, please bring your insurance card or other insurance information. You must be familiar with your insurance benefits, as any amount not covered by your insurance company is payable at the time services are rendered and these fees may include deductibles, co-payments or certain procedures not covered by your insurance policy.

As your dental insurance plan is a contract between you, your employer, and the insurance company, some carriers will not reimburse our office. In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.

Please understand that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. Your employer chooses your particular policy and if you are unhappy with its coverage, you should speak with your Human Resources Department. Only your employer can adjust benefits.

Your dental insurance company is required by the Colorado Insurance Commissioner to process, pay or reject all insurance claims within thirty (30) days. We file all insurance electronically, so your insurance company will receive each claim within days of the appointment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 45 days a finance charge of $5 will be added to your account.

Any account balance exceeding (60) days in age may be forwarded to a collection agency and/or attorney. All costs incurred in collecting unpaid fees will be charged to your account. These fees often exceed 50% of the unpaid balance.

We will do our best to maximize the insurance benefits that you are eligible to receive. Prior to completing any large treatment plan, we will submit a pre-determination to your insurance in order to determine what your out-of-pocket portion will be, as this amount is due the day of treatment.

The parent/guardian accompanying your child to our office is responsible for payment.

Dr. Van Tassell's treatment recommendations are based upon what he believes is in your child's best interest rather than on what your insurance covers.

A $35.00 fee will be assessed for any "returned check."

We require a minimum of 24 hours notice to reschedule an appointment. A $50.00 fee may be assessed on your account for any appointment missed without adequate notice. We do not allow repeated cancellations or short-notice changes.

I have read the above financial policy and understand my financial options and obligations as described.

_____ _____

Signature of Parent/Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____