Alpine Dentistry
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(619) 445-8896
www.alpinedentistry.com/

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FINANCIAL POLICY
| DOB:

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. 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.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office will bill your insurance plan and can also provide certain services, including a pre-treatment estimate which can be sent to the insurance company at your request. It is physically impossible for us to have the knowledge and ability to keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware that some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion. If your insurance fails to reimburse the dentist within 60 days after being billed by the dentist, Alpine Dentistry may bill you for the remaining amount due on the claim. Alpine Dentistry may also require payment in full at the time of service for future visits if your plan does not pay claims in a timely manner.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. If insured by Delta Dental or other carrier, and insurance payments are not made to the practice, the payment of the full amount is due at the time the service is rendered.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney’s fees, and court costs associated with the recovery of the monies due on the account.

ALL RETURNED CHECKS will be subject to a $25 fee returned check fee.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 24 hours in advance, you will be charged $50 per hour. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement. I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me. I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency or attorney to whom an unpaid balance has been assigned or referred by mail at any address that I provide to the dental office and/or any fax number, email address, or phone number.

Patient's signature: Date: