FINANCIAL POLICIES AND ACKNOWLEDGEMENTS

Thank you for choosing Park West Dental as your dental healthcare provider. We deliver the finest care at the most reasonable cost to our patients. Therefore, we ask for *payment at the time service is rendered* unless other arrangements have been made in advance. The fees charged are based on the skill, time, and professional judgment necessary to treat your dental condition. We have included below the details of our financial policy:

Payments at Time of Service:
We reserve the right to collect the estimated co-payment at the time of service. For procedures with multiple appointments, at least 50% of your estimate portion is due at the first appointment and the balance is due at the beginning of the final appointment.

Dental Insurance:
As a courtesy we will file your insurance claim for you. We offer this service to you as a courtesy only, and it is not meant to be a substitute for payment. We will attempt to collect from your insurance carrier their portion of the charges for your visit. We cannot guarantee that they will pay any amount for your treatment. Each plan has different exclusions and limitations and those exclusions and limitations change over time. Our office recommends dental treatment based on medical necessity and not on whether your insurance company will cover a procedure. ***It is your responsibility to verify your dental insurance coverage and to pay any amount not covered by your insurance company, regardless of the reason*.**
We will instruct your insurance carrier to send all payments directly to our office for reimbursement.

Pre-Determination of Insurance Benefits:
We will file, upon your request, a request for pre-determination of dental benefits from your insurance carrier. A pre-determination is a process whereby your insurance company tells you in advance of treatment what procedures may be covered and the amount of benefits your plan may pay towards those procedures and the amount you may be required to pay. A pre-determination of benefits reduces, but does not eliminate the risk of error in estimating your co-payment. *A pre-determination is not a guarantee of coverage*. A pre-determination sets forth your expected benefits based on the information provided to the carrier at the time of processing. If your plan changes, additional claims are received after the pre-determination is processed, or your oral condition changes then the pre-determination is not valid and may need to be resubmitted. Depending on your insurance carrier, a pre-determination may take up to three weeks to process.

Third-Party Financing:
We will be happy to assist you with applying for financing, should you so desire, with various third-party lenders. Arrangements for these options should be made in advance of your appointment.

_____ (*Initial*) Interest Charges:
Patient balances sixty (60) days and older will be assessed an interest charge of 1.5% per month, or 18% per annum with a minimum charge of $5.00 per billing period.

_____ (*Initial*) Collection Charge and Returned Checks:
Any account sent to an outside collection agency will be assessed a $50 collection fee. Any check returned for any reason by your bank will be assessed a $35 fee.

_____ (*Initial*) Missed/Cancelled Appointment Charge:
We understand unexpected emergencies arise which may cause you to miss or cancel an appointment with short notice. However, frequent occurrences affect our ability to provide quality, timely service to our patients. Any appointment that is missed or not cancelled within 1 business day (our business days are Mon-Fri) of the appointment will be subject to a charge of $25.00 after the first two occurrences. Future missed or cancelled appointments may require a deposit prior to rescheduling in addition to the missed/late cancel fee. No further appointment will be made until the fee is paid. Cancellations must be made during business hours. Messages left after 3pm will be considered to have been made on the next business day.

I have read, understood, and agreed to the terms outlined above. I understand that treatment cannot begin until this form is agreed to and signed.

_____ _____

Signature of Patient or Legal Guardian Date

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Printed Name of Patient or Legal Guardian