DENALI
DENTAL CARE

OFFICE FINANCIAL GUIDELINES

Financial responsibility on the part of each patient must be determined before treatment.
The patient is responsible for payment of all dental services. As a courtesy, this office will help prepare insurance forms, assist in making collections from insurance companies and will credit any collections received to the patient's account. It is the patient's responsibility to obtain and track annual limits, benefits and coverage. After insurance has been billed, any account balances over 45 days will be paid by the patient to the dental office. The patient can then pursue reimbursement from the insurance carrier. Patients who do not carry dental insurance agree to pay the cost of treatment at the time of service. Patients may apply for financing through our office or use cash, Visa, Master Card or American Express Card to make payment.

I agree to pay my co-pay and deductible at the time work is begun and agree to pay any remaining balance not paid by my insurance company. I understand that the fee estimate (treatment plan) listed for dental care is valid for a period of 45 days from the date it was given. I understand a fee will be added to my account for the return of any dishonored checks. I grant my permission to you or to your assignee to telephone me at home, on mobile or at my work-place to discuss matters related to my treatment. I certify that I have been given an opportunity to ask questions about the purpose of foregoing procedures, have had them explained to me, and my questions have been answered to my satisfaction. I agree to abide by the conditions outlined hereon.

_____ _____

Signature of patient, parent or guardian Date

APPOINTMENT COMMITMENT

When an appointment time is reserved in our office we have this set aside Especially For YOU. We set up the procedure and are ready. If the time does not work for you unexpectedly, we appreciate the kindness of 24 hours notice so we can meet the needs of another patient in your reserved time.

No call, no shows are difficult for our practice. If this happens, we will request that you either prepay for your visit in the future or walk in when the time works for your schedule and we will do our best to work in your appointment.

We always look forward to providing the very best for you and your loved ones. See you soon!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ ____/____/____

Signature Date

_____

Witness