PERIODONTAL & IMPLANT CENTER OF THE ROCKIES

P: (970) 999-5126
F: (970) 999-5928
4803 BOARDWALK DR.
FORT COLLINS, CO 80525

FINANCIAL POLICY

Periodontal & Implant Center of The Rockies believes that part of good dental care is to establish and communicate our financial policy to our patients. We strive to give the best care to our patients and would like you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of your visit. An evaluation of your dental needs may range from $100.00 to $650.00 dollars on most cases. This fee range is dependent upon any images our office may need to establish and provide a treatment plan for you. Our office will accept cash, check and most credit cards. Payments will include any unmet deductible, co-insurance, co-payment and non-covered charges from your insurance company. If you do not carry dental insurance, payment in full is expected at the time of your visit. We do require personal information to verify your identity; this information may be used for billing and collection purposes. If outstanding balances are left unpaid your account may be subject to deferral to a collection agency of the practice's choosing. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party.

2. **INSURANCE.** We will file claims to most insurance plans on behalf of our patients as a courtesy. Please remember that insurance is a contract between the patient and their insurance company and ultimately the patient is responsible for payment in full of the services rendered at our office. If your insurance company does not provide payment to the practice within 30 days from the date of service, you will be billed for any outstanding balance. Our team members cannot guarantee your eligibility and coverage, though we will attempt to verify dental benefits for our patients. Be sure to check with your dental insurer regarding your benefits and coverage details of your dental plan. Insurance coverage is only an estimation. The services covered by the insurance companies vary widely depending on the insurance company and the plan. In the event your insurance company determines a service is "not covered" you will be responsible for payment in full to our office for any rendered services. Payment is due upon receipt of statement from our office.

3. **RETURNED CHECKS** will incur a $20.00 service charge. You will be asked to bring cash, money order or credit card to cover the amount of the returned check plus the $20.00 service charge to pay the balance prior to receiving services from our practice. Stop payments constitute a breach of payment and are also subject to a $20.00 service charge and collection action. All bad checks written to our office are subject to collections.

4. **APPOINTMENTS.** I understand that I will be subject to a $50 fee for any cancellation without a 48 hour business day notice. Cancellations at more than 3 instances will be subject to dismissal from our office.

5. **ACCOUNTING PRINCIPALS.** Payment and credits are applied to the oldest charges first. Insurance payments are applied to the date of service that treatment was rendered. Patients with outstanding credit on their account can expect reimbursement to the form of payment that was used when paying for treatment, once our office has audited the patient's account. If the method of payment previously used is no longer effective our office may reimburse the patient via check.

6. **CONSENT**. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted by law, I consent to your use and disclosure of my protected health care information to carry out payment activities in connection with claims submitted from this office. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Periodontal & Implant Center of the Rockies.

7. **BILLING OFFICE.** If you have any questions regarding financials or your billing statements, please call our business assistants.

Name of patient, parent, or guardian: _____

Signature of patient, parent, or guardian: _____

Date: _____