Englewood Dental Center

OFFICE POLICY

Payment will be expected in advance at the time of service for all non-contracted fees and co pays.

Insurance contracts: If we have a "Participated Contract" with your Insurance carrier, we will accept assignment on all Covered Services and bill your Carrier for you. You are responsible for the Co pay, Coinsurance, and Deductible for all non-covered services.

Insurance plans represent a contract between yourself and the insurance company. These contracts are not between the doctor and the Insurance Company. We will do our best to help you obtain benefits, but we cannot be responsible if your Carrier does not pay. Further, if a member of our staff advises you that you are fully covered or implies that you will owe nothing, it is your responsibility to contact your insurance company for verification. Therefore, it is your responsibility to make certain your carrier makes prompt payment, and to handle any disputes that may arrive.

If your insurance is found to not be in force on the date dental services are provided, you will be responsible for the full balance. A finance charge of 18% APR (1.5% a month) will be added to the total balance on all accounts over 60 days past due. In the event of default Patient promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Third party financing may be available for patients requiring extensive treatment ($500 or more) through CareCredit. Chase Health Advance and Springstone Financial . This type of financing must be approved in advance. The terms of this contract consist of six equal installments, free of interest or finance charges. The total financed amount however, must be paid in full within 6 months.

If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, to rectify an injustice, or to preserve a friendship.

Missed appointments: Our policy is to charge for missed appointments unless a cancellation is received at least 48 hours in advance. **The charge is $75 per hour of scheduled time.**

Children in the office: Please make arrangements for your non-scheduled children prior to your visit. Children should not be left unattended in the reception area. All children 17 years of age and under scheduled for treatment must have a parent or legal guardian present in the office during their appointment.

Cellular phones/pagers: We request all cellular phones and pagers be turned off or to silent mode during your appointment.

Family/Friends: In order to comply with regulations set by Boulder Dental Center, and for the safety and comfort of our patients and employees, no friends or family members will be permitted to accompany patients in the treatment area during the appointment. Any patients with special needs can make necessary arrangements with the office manager prior to your appointment.

We reserve the right to dismiss any patient from our practice for inappropriate behavior in our office or on the phone.

I acknowledge that I am responsible to pay all charges for treatment administered by Boulder Dental Center as outlined above and that if my account is placed with a collection agency for non-payment that I will be responsible for all collection costs, including court costs and associated attorney fees.

I have read the policies and agree with the terms outlined above.

Responsible Party Signature: _____

Printed Name: _____

Date: _____