OFFICE FINANCIAL POLICY

Our office accepts cash, person checks, credit cards and Care Credit. There is a $25.00 returned check fee due and payable for each check payment returned to us by your bank as well as all other remedies allowed by 7-15-l sequence U.C.A.

***** Estimated co-payment with insurance, payment without insurance is due**

at time of services rendered.* * *

For patients with insurance coverage: Benefits and eligibility are received prior to the time of visit. Information is determined that day and time. An ESTIMATE will be given to you for a co-payment. Your insurance is a contract between you and your insurance company. As a service to our patients, we will bill your insurance carrier, provided that the proper information has been provided to us. The ultimate responsibility is that of the patient or guarantor is to pay in full.

For Patients with no insurance coverage: We require payment in full for services rendered on the day of treatment. We offer a 5% discount when paying with cash or check. We accept CareCredit to assist with payments.

For emergency appointments and surgery: Payment is due the time of treatment for the procedures rendered for emergency. Insured patients are expected to pay estimated co-payment. Patients with no insurance must pay in full at the time of service. A 5% discount can be applied when paying with cash or check only, for self-pay patients.

A service charge of 1.5% per month (18% annual rate) on the unpaid balance will be assessed on all accounts exceeding 30 days from the date of service.

In the event that this account should go to a collection agency or attorney for outside collections, a non-refundable collection service fee of up to 40% of the principal amount will be added to your account. This amount is in recognition of the costs associated with collection action processing.

1. I understand and agree that this dental office does not represent my dental insurance company and that this office cannot make any representation or warranty that my dental insurance company will cover all or any portion of the dental service provided by this office.
2. I further understand that I will be billed and will be responsible to pay for any and all amounts not paid or covered by my dental insurer.
3. I understand that such bills will include amounts incurred from deductibles, co-payments and amounts not paid by my dental insurer due to the exhaustion of my benefits,
4. I confirm that no representation has been made to me by anyone in this office that is contrary in any way to the above notice and disclaimer.
5. I further confirm that any statement made by anyone in this office concerning my dental insurance coverage cannot be relied upon as a guarantee of coverage.

I have read this notice and disclaimer concerning my dental insurance coverage and rights. I have signed and dated below.