Idaho Falls Dental Group
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FINANCIAL POLICY

PAYMENT OPTIONS

We desire to make dental treatment affordable to all of our patients and to make every effort to fit your care within your budget and schedule. Therefore, we offer the following financial options.

1. **Patients with insurance** - a partial payment is required for each treatment beyond routine cleaning and exams. An updated statement will be sent after insurance has paid. *** **NOTE: We are not a Medicaid Provider.** ***

2. **Patients without insurance** - Payment for dental services are due at the time of treatment unless prior arrangements have been made. A finance charge of 1.75% per month (21% per annum) after 90 days or a minimum of $0.50 per month applies. Additionally, any account referred to collections will have a 35% fee added to the total balance in order to help with some of our costs. There is no interest or service charge on outstanding balances less than 90 days old.

3. **Other** - for patients requiring extensive treatment, payment options can be discussed. For your convenience, we offer Care Credit financing or in office financing upon credit approval.

FOR OUR PATIENTS WITH DENTAL INSURANCE

Because we understand that dental insurance plays a role in helping defray some of the costs of dental care, we would like to share with you the following facts about dental insurance.

Dental insurance is not meant to be a pay-all. It is meant only to assist in paying for your dental care. Dental insurance plans have no correlation to actual patient needs. As such, many routine and necessary dental services may not be covered, even though you may need those services. Our responsibility is to provide you with the best treatment to meet your needs, not try to match your care to your insurance plan limitations.

Please turn over and sign.

Many plans pay less than what you might expect. We are happy to submit your claims and help you receive the maximum benefits due to you, but please understand that we cannot accept responsibility for collecting an insurance claim or negotiating disputed claims.

***Please note: If you are late for your scheduled appointment, we may need to reschedule you. This could result in a broken appointment fee.**

***Also, not providing a 24-hour notice of cancellation for a scheduled appointment may result in a broken appointment fee.**

I hereby assign to the dentist all payment for dental services rendered. I have read and understand the above policy.

Regardless of insurance coverage I understand payment is due at time of service unless prior arrangements have been made. In the event that a claim is submitted to insurance the balance is due 90 days after the insurance claim has been processed. I am responsible for payment of all dental fees for myself and/or my dependants within 90 days. There is no guarantee of refund based on treatment outcome.

I authorize the Idaho Falls Dental Group to furnish information to insurance carriers concerning treatment for myself or my dependants. I understand that a credit check may be obtained to ascertain in-office financing options.

I, the undersigned client or guardian, agree to pay for all services rendered, or goods sold to me or my ward. I further agree that in the event of non-payment of any amounts due under this agreement, I will pay interest thereon at the rate of 1.75% per month and pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% for the unpaid balance due.

Signature____ **Date**____________________

Print____