



Financial Policy

Thank you for choosing Coal Creek Dentistry. We are committed to your successful treatment. Please sign this to acknowledge your understanding of our Financial Policy.

Payment is due at the time of service.

We accept cash, checks, Visa and MasterCard.

If you have insurance, the payment of your deductible and estimated patient portion is due at the time of service.

You and Your Insurance

You have a contract with your dental insurance company. We are not a party to that contract, and while we do our best to obtain information from your insurance company, it is ultimately your responsibility to understand your policy and its limitations. When we accept your insurance, you are still responsible for charges in full for all treatment.

Estimates

We provide an estimate that you should consider a guideline until final insurance payment is received and your account has been reconciled. We make every effort to provide accurate estimates, but our office can make no guarantee that insurance payments will match our estimates.

Claims

Claims are submitted promptly to your insurance company after treatment. Any claim that is not paid after 61 days is billed directly to you.

Predeterminations

At your request, we will gladly process your predeterminations, but please be aware that predeterminations are not guarantees of payment.

Usual and Customary Rates

We charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.



Missed Appointments

If you cancel an appointment 24 hours in advance, no charge will be made. If the appointment is on Saturday, we require 48 hours advance notice, as Saturday appointments are in very high demand. Without this advance notice, you will be charged \$72.00 per half hour missed. Please note that if you miss a Saturday appointment without notice, we will be unable to offer you another Saturday appointment.

Service Charges

Accounts due over 30 days are assessed a monthly finance charge of 1.5%, or an annual rate of 18.0%.

Services Not Covered

You (or the party responsible for your account) agree to provide total payment for procedures performed in this office, including any treatment not deemed to be a benefit of your dental or other insurance.

I (or the party responsible for my account) have read, understood, and agree to this Financial Policy.

Signature

Date