MOUNTAIN
SHADOWS®
FAMILY DENTAL

Patient Name: _____

Dental Insurance Policy

Mountain Shadows Family Dental proudly accepts most dental PPO insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable ***estimate*** of patient co-payment and insurance contributions. This ***estimate*** is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted**. We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

----------PATIENT ACKNOWLEDGMENT AND AUTHORIZATION----------

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Mountain Shadows Family Dental. The assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: _____ Date: _____

Cancellation Policy

Mountain Shadows Family Dental makes an effort to see patients on time in order to give patients the care they deserve. Therefore, we ask that you please give 24 hour notice if you are unable to keep your scheduled appointment. We reserve the right to charge a $50.00 cancellation fee for lack of proper notice. We will make exceptions in the event of reasonable emergencies. In the event that you have repeated failed appointments, we may require a deposit of 25% for all appointments requiring more than 30 minutes. The deposit will count toward the total patient portion due. In the event that the reserved appointment is missed, the deposit is non-refundable.

I understand and agree.

Signature: _____ Date: _____

Account Balances

I understand that if my account is not paid in full within 90 days, a $25.00 or 25% (whichever is greater) of the total bill will be added to the outstanding balance and will be turned over to an outside collection agency for further processing. No additional appointments will be made for delinquent accounts until they are brought current. For your convenience we accept Visa, MasterCard, Discover, American Express, Personal checks, and Cash. **Extended payment plans are accepted through Care Credit.** There will be a $35.00 NSF fee for all returned checks.

I understand and agree.

Signature: _____ Date: _____