FINANACIAL INFORMATION

Taking care of you and yor family is our highest priority. That is why, when it comes to talking about finances, our goal is to privide you with clear information regarding our dental fees and your payment options. At the onset of treatment, we will provide you with an estimate of the fees expected. Treatment needs can change for a variety of unforseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

When estimating insurance coverage, we must also stress the work ***estimate*** as dental benefits are determined by each patient's dental contract. Most dental insurance plans are designed to ***assist*** patients with their dental expenses. Very few dental plans fully cover all dental services.

Please read and *initial each statement and date below*. If you have any questions regarding any of this information, please ask us – we are heere to help you.

_____ I will receive an appointment confirmation at least 2 days in advance of my appointment. I understand that ther is a cancellation fee of $50 for appointments cancelled or broken without 48 hours notice.

_____ An 18% annual finance charge will be applied to any balance on accounts that are 90 days past due. Monthly finance charges are 1.5%, with a monthly minimum of .50.

_____ My estimatied portion & co-payments for treatement rendered are due at the time of service unless prior arrangements have been made.

_____ I understand that the Treatment Plan provided to me is for my future treatment needs and is only an estimate regarding my insurance benefits. I am responsible for all charges, including finance charges.

_____ I acknowledge & understand that I am ultimately responsible for knowing and understanding my dental insurance benefits.

_____ I understand that I am responsible for the prompt payment of my account regardless on any pending insurance claim or settlement.

_____ I acknowledge & understand that ***Westcliffe Family Dental*** is a Preferred Provider for: Aetna, Anthem(Unicare), Ameritas, Asurius, Carington, Cigna, Connection Dental, Delta, Dental Select, Guardian, Kansas City Life, Lifemap, Lincoln, Metlife, Premera, Principal, Regence, Sunlife, United Concordia, United Healthcare ONLY. It is my responsibility to know if my insurance company requires me to see one of their preferred providers.

_____ I acknowledge & understand that even if I have dual insurance coverage, there may be instances where the two insurances will not pay 100% of my bill. In such cases, I am responsible for any amount not paid by insurance(s).

PERSON RESPONSIBLE FOR BILL

Name_____ Phone # _____

Address _____ Driver's License _____

City _____ State _____ Zip Code _____ Soc. Sec. # _____

I have read all the information on this form and the information I have provided is true and correct to the best of my knowledge. I will notivy your office of any changes to my personal information, insurance plan and/or health status.

Signature of Responsible Party _____ Date _____

Person signing is the: Patient Parent Guardian Other