**White River Dental Hygiene**

**73521 Highway 64, Meeker, CO 81641**

**970-878-9967**

**Written Financial Policy**

Patient portion is due in full at each appointment. Returned check fees of $25.00 will be applied to each returned check.

As a condition of your treatment, financial agreements must be made in advance. If you choose to discontinue care before treatment is complete, any refund given will be determined upon review of your case. Any dental services performed without previous financial arrangements must be paid for at the time services are rendered.

As a courtesy, we will file your insurance claims; however, we cannot accept responsibility of negotiating claims with your insurance company or any person. Our office makes every attempt to obtain current benefit information from your insurance carrier prior to your appointment. As the insured member, you are ultimately responsible for understanding your benefits structure and realizing that your insurance plan is a contract between your employer, the benefit provider and you. Please understand that verifying your dental insurance is not a guarantee of payment. **Our office will provide treatment based on what is best for you, not what your insurance will cover. You are responsible for your total obligation should your insurance benefits result in less than anticipated coverage.**

Outstanding insurance balances remaining after 60 days, will be billed directly to you. **You agree to be responsible for payment of all services rendered. It is our policy to turn unpaid accounts over to a collection agency when the accounts reach 90 days past due.** In the event a legal suit or outside collections are necessary to enforce payment of the account, you agree to pay for all collection fees and /or attorney’s fees and court costs as may be deemed reasonable.

**Payment Options**

Cash, Check, Visa, MasterCard, American Express

We offer a 10% courtesy for those patients without insurance.

For comprehensive treatment plans that exceeding $500.00, a $50.00 deposit is required to secure the appointment.

**Late/Cancellation Policy**

At White River Dental Hygiene, we value your time. To ensure all patients receive quality care, we ask that you arrive to all appointments 10 minutes prior to your schedule appointment time. This allows us the necessary time to review your healthy history and any changes in your insurance benefits.

If you arrive more than 10 minutes late, we may not be able to complete all treatment that was scheduled.

If it is necessary for you to cancel an appointment, please do so with a 48 hour advance notice.

**Privacy Practice Policy**

I hereby authorize payment directly to White River Dental Hygiene from the insurance benefit provider otherwise payable to me. I grant the right to White River Dental Hygiene to release my dental history, and other pertinent information about my dental treatment to third party payers.

I have read and understand all policies and have asked any related questions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Parent or Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

------------------------------------------------------------------------------------------------------------------------------------------

I hereby authorize the following individuals to bring my child to appointments and have indicated if they have authority to authorize treatment or changes in treatment plans:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ can cannot authorize new treatment or treatment changes

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ can cannot authorize new treatment or treatment changes

Name Relationship