MOUNTAIN SPRINGS
DENTAL

OFFICE FINANCIAL POLICY
Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment is part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL
Understand that regardless of any insurance status, you are responsible for the balance due on your statement. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical fees, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS
Unless we receive notice of cancellation 48 hours in advance, you will be charged $50. Please help us serve you better by keeping your scheduled appointments.

INSURANCE
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.**

Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT
FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at time of service.
I understand that a billing charge of $15 will be added to my account for any returned/unpaid checks.

Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third-party debt collection agency.

I hereby assign all dental, medical and / or surgical benefits, to include major dental benefits to which I am entitled, including insurance, and any other health plans to Mountain Springs Dental. I have read and understand the financial policy of this office.

ELECTRONIC COMMUNICATIONS: I consent to receiving HIPAA-compliant communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Messages/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying "STOP".

Signature of Patient: _____Date:_____ Cell Number:_____

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Parent/Guardian Signature:_____ Date:_____ Cell Number:_____

Spouse/Parent/Gaurdian:_____ Date: _____ Cell Number: _____