

Mountain Dental Financial Policy

At Mountain Dental, our Doctors and staff are dedicated to provide you with the best quality dental care possible. People you know. Care you trust.

Treatment Estimates

The treatment estimates provided to you are based upon the information available to us, from your insurance company. **Please remember that this is only an estimate of the cost of your care.** Please ask the doctor or a staff member if you have any questions regarding your proposed dental treatment.

Your estimated insurance benefit may differ due to a number of reasons specifically related to your plan, and could include but not limited to:

- Exclusions and limitations of your insurance policy
- Waiting periods
- Use of alternative fee schedules by your insurance company
- Age restrictions
- Previous treatment already billed to your insurance company
- Specific treatment code restrictions

The cost of all dental care is ultimately the responsibility of the patient or their legal guardian, regardless of insurance coverage. As a courtesy, we will assist you in the process of submitting your dental insurance claim.

If you have any questions regarding your insurance benefit, we encourage you to contact your insurance company for further clarification. At your request, we will be happy to file an estimation of benefits on your behalf to your insurance company.

All patient co-pays and co-insurance are due in full on the day your service is provided.

Missed Appointment(s)/Cancellation Policy

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best service to our patients, we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. However, a charge may be assessed for multiple missed or short notice cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Collection Policy

A \$35.00 late payment processing fee will be added to any balance over 90 days and we reserve the right to run a credit report at any given time, for collection purposes.

I understand the above statements and agree to be financially responsible for my care, even in the event my insurance company denies benefits.

Patient/Guardian Signature_____ Date:_____