Davidson Family Dental
2624 Commercial Way, Ste C
Rock Springs, WY 82901
307-362-4005

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient's name:

Payment Options:

1. Cash
2. Checks & Money orders
3. All Major Credit Cards
4. In Office Financing (upon approval)

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we request that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.
Our insurance estimates are based on information provided to us by your insurance carrier, they are in no way a guarantee that services will be covered. Our office is happy to bill your insurance company for you and accept assignment of benefits, but the entire bill ultimately remains the patient's responsibility. It is up to the patient to resolve any conflicts with their insurance company. If the patient is a minor, the custodial parent is legally liable for any bills incurred at this office

ADULT PATIENTS
Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT
The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

The estimated patient portion of services rendered is expected on the date of service.
We require at least half of the estimated patient portion for **dentures, crowns, bridges** or any other fixed or removable appliance are paid on the day services are rendered. The remaining half of the estimated patient portion is required on the placement or delivery date.

INSURANCE
We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your

employer, and your insurance company. Our office is happy to bill your insurance company for you and accept assignment of benefits, but the entire bill ultimately remains the patient's responsibility. It is up to the patient to resolve any conflicts with their insurance company. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately.

MEDICAID/ WORKER'S COMPENSATION

If you are covered by Medicaid or Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the office on the date of service.

We will verify patient eligibility status before each scheduled appointment. Without verification of coverage, **you** will be responsible for the **full/entire** balance of your account. As a courtesy to you, your account will be billed to Medicaid, when we receive all necessary information. If you elect to have a procedure done, that Medicaid does not cover, you are responsible for all non-covered portions.

Payment for non-covered benefits will need to be paid before the procedure is performed. No treatment will be rendered until payment is received.

Medicaid only pays for specific procedures based on **age** and **eligibility**. The list of coverage procedures for an adult on Medicaid is very limited.

I understand that I am responsible for all debts incurred that are non-covered benefits by Medicaid.

Finances charges will be applied to any outstanding balance at a rate of 1.50% per month (annual percentage rate of 18%).

I understand that I am responsible for all debts incurred. If my account is assigned to a collection agency, I understand that I am responsible for all attorney fees, court costs or delinquency fees that may be incurred during the collection of my debt. I understand that the delinquency fee will be equal to 50% of the principal amount owed. Any credits not requested within 2 years will be adjusted to a zero balance and retained by Davidson Family Dental due to additional accounting and billing.

MISSED APPOINTMENTS

We understand how valuable your time is. Therefore, we have set aside time to see you at a specific date and time. However, events sometime come up that require you to change your plans. To avoid a **$50.00** fee, please notify our office 24 hrs. in advance of any changes to your schedule appointment.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company.

Responsible party signature Date