Charges for all services are the responsibility of the patient, whether or not covered by insurance. We will file insurance claims for patients if we have a current copy of the patient's insurance card on file. However, all patient payments, non-covered service charges, and deductibles as required by your insurance, are due at the time of service. If you are not covered by any dental insurance plan or this practice is not a participating provider with your dental plan, full payment of all office visits and other service charges is expected at the time of services are provided.

Each insurance plan has a different set of procedures that are eligible for payment and may have limits on the number and timing of visits, x-rays, and procedures. We may not know at the time of your visit if your insurance company will pay for all services and you may not be notified that a service is not covered at the time of your visit. If your insurance company does not pay for these services , you accept responsibility for full payment of these charges. Charges for certain procedures must be paid for, by you, prior to having the service provided.

Payment-We accept cash, Visa, Master Card and personal checks. We also participate with Care Credit patient financing.

Returned Checks-Occasionally, a check written to us is returned unpaid. Returned checks must be paid in full within 10 days of notification plus a $40 fee. The balance of your account must be paid in cash, money order or cashiers check.

Scheduling-Patients who do not show up for an appointment, arrive too late, or cancel with less than a 24 hour notice, may be billed and are responsible for a $50 cancellation fee. Broken appointments for surgery or major procedures will result in a $100.00 charge due to the amount of time scheduled and advance planning required.

Medicaid/Healthy Montana Kids No-Show Policy- A "no-show" is someone who has failed to keep a scheduled appointment or fails to cancel in a timely manner. We will allow one no-show per patient. If there is a second no-show you will be released from our practice. In order for our office to stay on schedule, we ask that you please arrive to your appointment on time. If you are late, there is a possibility that you will not be seen and will be considered a no-show.

Treatment plans may change and I will be responsible for the work actually completed.

I agree to pay finance charges of 1.5% per month (18% APR) on any balance 30 days past due.

Any account 90 days past due will be turned over to our collection agency. If sent to collections, I agree to pay all related fees and court costs. I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 45% of the balance, including attorney/court costs will be added to the balance of my account.

Please sign below

_____ _____

Client Signature Date