

Thank you for choosing Endodontics of Colorado for your care. We are committed to providing the highest quality treatment and operate on a fee-for-service basis. If you have dental insurance, we will gladly assist you in obtaining your maximum allowable benefits. Financial policies are set by practice administration and cannot be modified by staff. Your understanding of our financial policy is appreciated.

PAYMENT POLICY

Financial arrangements must be completed prior to the start of treatment. **Payment is due at the time services are rendered** unless prior arrangements have been approved by our office. We accept cash, checks, major credit cards, and CareCredit. Payment arrangements are not guaranteed and must be approved prior to treatment. Balances must be paid according to the agreed payment schedule. Failed payments may result in cancellation of the payment plan and the remaining balance becoming immediately due. Returned checks or declined payments are subject to a \$35 processing fee.

INSURANCE RESPONSIBILITY

Dental insurance is a contract between the patient and their insurance company. As a courtesy, our office will assist in submitting claims and providing necessary documentation. However, insurance benefits are not guaranteed.

The patient or policyholder is responsible for understanding their insurance benefits, including deductibles, co-payments, co-insurance, out-of-network limitations, usual and customary allowances, prior authorization requirements, and any other benefit limitations. Any portion of treatment not covered by insurance, including deductibles and co-insurance, is the responsibility of the patient and is due at the time services are rendered.

PRE-TREATMENT ESTIMATES

Upon request, a treatment estimate will be provided following a complete endodontic evaluation and prior to treatment. **Estimates are based on information provided by your insurance company and are not a guarantee of payment.**

CREDIT BALANCES & REFUNDS

Any credit balance resulting from insurance payments will be refunded to the responsible party after all insurance claims have been finalized. The office reserves the right to verify all payments, insurance adjustments, and account activity prior to issuing any refund.

OUTSTANDING BALANCES

Accounts with balances remaining unpaid after **60 days from the original statement date** will be referred to a third party collection agency. If collection action or legal proceedings are required to recover an outstanding balance, the patient agrees to pay all collection costs, charges, and reasonable attorney fees.

AUTHORIZATION

I authorize the dentist to release any information, including diagnosis and records of examination or treatment, to third-party payers and/or other healthcare providers as necessary. I authorize payment of insurance benefits directly to the provider and agree to be responsible for payment of all services rendered to me or my dependents.

ACKNOWLEDGMENT

By signing below, I acknowledge that I have read and understand the financial policy of Endodontics of Colorado and agree to be responsible for payment of all services provided.

Signature: _____

Date: _____

Print Name: _____

Relationship to Patient: _____