# Highlands Dental Financial Policy

**Please initial each as your acknowledgment of the following policies:**

**Personal Information:**
___Please inform us of any changes in your address, phone number(s), email addresses, and insurance information.

**Insurance:**
___Complete and accurate and or updated insurance information must be provided at every visit (IE: current insurance card). Highlands Dental reserves the right to deny service, reschedule, or make self-pay any appointment at any time if this information is not present.

___By signing below, you authorize Highlands Dental to file with your insurance carrier and assign payment of dental benefits to Highlands Dental. You authorize release of any and all dental records and information necessary to process any claim generated by a service you or your dependent(s) receive. It is your responsibility to be familiar with your own insurance policy so that you are aware of what services are covered and/or non-covered. You will be responsible for payment of dental services provided if your insurance denies payment.

___All co-pays are due at the time of service or your appointment will be rescheduled.
Any previous balance due at any appointment will be collected at check-in or you may be asked to reschedule until payment is made. Highlands Dental cannot waive or change co-pays or balances due as per your agreement/contract with your insurance carrier.

**Non-Insured/Self Pay:**
___Payment in full is due at the time of your appointment. We offer a 10% cash discount for all professional services.

**Account Balances:**
___ Payment is due immediately upon receipt of your statement. We accept cash, checks, Visa, MasterCard, and Discover.

___There will be a $10.00 billing charge assessed for every 30 days the account is past due. Should your account become delinquent, Highlands Dental may deny services. If your non-paid account is sent to our outside collection agency, the undersigned Responsible Party agrees to pay all costs associated with collection, including collection agency and attorney's fees. Furthermore, you and your family members will be terminated from our practice due to non-payment.

___There will be a $25.00 fee for any returned checks. Cash and credit cards will only be accepted for future payments.

My signature below indicates that I have read and agree to the above Financial Policy and terms. I further agree that a photocopy or digital image of these agreements shall be as valid as the original.
(Parent or Guardian must sign for patients under 18 years of age.)

Patient:_____

Guardian/Guarantor:_____

Relationship to Patient:_____

Signature:_____

Date:_____