Highlands Dental Financial Policy

Please initial each as your acknowledgment of the following policies:

Personal Information:
_____ I will inform Highlands Dental of any changes in my 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 and verifiable at the time treatment is administered.

_____ By signing below I authorize Highlands Dental to file claims with my insurance carrier and assign payment of dental benefits to Highlands Dental. I authorize the release of any and all dental records and information necessary to process any claim generated by a service I or my dependent(s) receive. It is my responsibility to be familiar with my own insurance policy so that I am aware of what services are covered or non-covered and any frequency limitations of my policy. I will be responsible for payment of dental services provided if my insurance company denies payment.

_____ If my insurance company has not paid my claim in full within 90 days of treatment I understand that I will be required to pay this balance and then I will need to seek reimbursement from my insurance company.

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

Non-Insured/Self Pay:
_____ Payment in full is due at the time of my appointment. Highlands Dental offers a 5% cash discount for all professional services.

Account Balances:
_____ Payment is due on the day services are rendered. We accept cash, check, Visa, MasterCard, and Discover.

_____ There will be a $10.00 billing charge assessed for every 30 days the account is past due. Should my account become delinquent, Highlands Dental may deny services. If my 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, I and my family members will be terminated from our practice due to non-payment.

_____ There will be a $25.00 fee for any returned check. Cash and credit cards will only be accepted for future payments.

_____ My dental records can be sent to another office digitally at no charge to me. Alternately, hard copies can be scanned and sent for a fee: pages 1-10: $16.50, pages 11-40: $0.75/page, pages 41+: $0.50/page.

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:_____