Financial Policy

1. Our office is committed to providing the best possible dental care and we believe that a clear understanding of our financial policies is an important step in meeting that goal. We are **not** in network or a participating provider with any insurance companies, except Delta Dental. However, we will help you to maximize your dental benefits in our office.
2. Our fees are reasonable and customary for quality care in this area, but as different insurance companies apply different fee schedules (which vary greatly), we may or may not fall within what they consider to be usual and customary.
3. Please remember that insurance is a contract between you and the insurance company. Despite verification by phone, your carrier may still deny payment on a claim. You will be responsible for paying all charges not covered by your insurance company.
4. Many patients appreciate the convenience of retaining a credit card on file to charge balances in excess of 60 days. Is this something you would like to do? □ Yes / □ No
   If yes, please provide CC# and Expiration Date _____
5. We have a 24-hour cancellation policy. We reserve the right to charge a fee of $100 per hour scheduled if less than 24 hours notice is given.
6. In the event that an account becomes delinquent, you will be responsible for all legal and administrative fees involved in collecting monies owed. There is also a $75 returned check fee.
7. The parent or guardian who brings a child for an appointment is responsible for paying the patient portion and any prior balance on the day of appointment.

By signing below I acknowledge:

1. I have read, understand and accept all conditions of this financial policy.
2. I certify that if I have insurance coverage, I assign directly all insurance benefits otherwise payable to me (for services rendered) to Desert Sky Dentistry, LLC. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I understand that this office will assist with insurance submissions (primary and secondary only); however, my estimated patient portion is due the day services are rendered. I hereby authorize Desert Sky Dentistry, LLC to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance forms, both manual and electronic.
3. I have read and received a copy of the Notice of Privacy Practices (HIPPA).
4. I authorize Desert Sky Dentistry, LLC to perform any necessary dental services that I may need, with my informed consent, in regards to my diagnosis and treatment. I also authorize release of any information, including diagnosis and the records of any treatment or examinations rendered to my dependent or me during the period of such care to third party payers and/or health practitioners.
5. If opted, I authorize Desert Sky Dentistry, LLC to charge balances over 60 days to the credit card on file that I have provided above.

Signature_____ Date _____

Print Name _____ Staff Witness _____