



## 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. 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. Often times patients find it to be convenient for them to keep a credit card on file for balances over 60 days to be charged to. 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 up to \$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 at that visit.

By signing below I acknowledge:

1. I have read, understand and accept all conditions of this financial policy.
2. I certify that I have insurance coverage if indicated above, and assign directly to Desert Sky Dentistry, LLC all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I understand the 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.
3. I have read and received a copy of Notice of Privacy Practices (HIPPA).
4. I authorize Desert Sky Dentistry, LLC to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. 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 \_\_\_\_\_