Canyon Dental Group, LLC

Dr. Bart Wolthuis

Dr. Jared Wolthuis

**Insurance and Financial Policy and Federal Truth-In-Lending Statement**

At **Canyon Dental Group**, we believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

**Initial Each Item**

\_\_\_\_\_\_\_\_\_\_Your dental benefits are based upon a contract made between your employer and insurance company. **If you have any question regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will not pay for completion of your dental care. It is only meant to assist you.**

\_\_\_\_\_\_\_\_\_\_We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with many companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a “pre-treatment authorization” with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage, and it may delay treatment, but will give you the most accurate out of pocket figures you may be required to pay.

\_\_\_\_\_\_\_\_\_\_We will bill your insurance as a courtesy. If your insurance does not pay within 90 days. **Canyon Dental Group, LLC** reserves the right to request payment in full for services from you and allow you to collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

\_\_\_\_\_\_\_\_\_\_I authorize the dentist or his designees to release financially identifiable information, treatment description and information, either electronically, by facsimile, or in paper form to my insurance carrier or any related entities that require such information to be submitted.

\_\_\_\_\_\_\_\_\_\_Canyon Dental Group, LLC requires payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash, and checks (only for existing patients with established payment history). If you are in need of an extended finance option, we also work with Care Credit, who offers 3, 6, 12 or 18 month “same as cash” or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

\_\_\_\_\_\_\_\_\_\_You will be changed interest of 1.5% per month (18% per annum) on the unpaid balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. If this account is sent to collections, you agree that in addition to any amount left owing to Canyon Dental Group, LLC, you will be responsible for interest incurred on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys’ fees, with or without suit, incurred in collecting any past due balance, and a collection fee.

\_\_\_\_\_\_\_\_\_\_A specific amount of time is reserved especially for you, consequently it is imperative you keep your appointment. If you must change your appointment, we require at **least 24 hour** notice to avoid a **cancellation fee** (emergencies are an exception).

\_\_\_\_\_\_\_\_\_\_I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and /or rescheduling on my answering machine or with a family member.

\_\_\_\_\_\_\_\_\_\_I acknowledge that I have been offered or received a copy of the office’s Privacy Policies. I agree to disclose to the dentists, names of any individuals with whom I authorize the dentists to discuss my dental care.

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Signature of Patient, Parent of Guardian Date Relationship to Patient