WESTMOUNT DENTAL ARTS

Financial Policy Acknowledgement

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our business team. We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide.

- We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, Discover and American Express. We have also partnered with third-party companies, to offer the flexibility of deferred interest and extended payment options.
- We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.
- We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, any appointment missed may be subject to a missed appointment fee of **$25**. After 3 appointments missed or cancelled without a 24 hour advance notice, we may no longer be able to see you as a patient. Should you find it necessary to reschedule an appointment, please provide us with a notice of **24 hours** to avoid being charged a missed appointment fee. If you find that you are running late to your appointment please call to let us know. If you are more than 15 minutes late, your account will be charged a $25 and your appointment will need to be rescheduled.
- If your check is returned for any reason, you will be charged a returned check fee of $25. Also, we will not accept post-dated checks.
- Our fee estimate of your dental treatment may only be extended for a period of 3 months from the date of your examination.
- A service charge of 1 ½ % per month (18% per annum) on an unpaid balance will be charged on all accounts exceeding 60 days.
- As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefitsas a form of payment to help reduce your immediate out-of-pocket expense. We are participating providers in some dental networks. Check our websitewww.westmountdentalarts.com for the most updated list. Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.
- Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment. It is your responsibility to understand the type of dental insurance you have and the benefits selected by you and/or your employer. You (not the insurance company) are responsible for the fees of services rendered.
- Please note, we are NOT a Medicare Advantage provider.

»I authorize release of any information concerning my/my child's healthcare recommendations and treatment for the purpose ofevaluation and administering claims for insurance benefits.

»I authorize payment of insurance benefits directly to Westmount Dental Arts.

»I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.

»I agree to pay any applicable deductibles and estimated patient portions on the date the dental services are rendered.

»I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.

»I agree to pay the total cost of dental services rendered on the date of service if I/my child does not have dental insurance benefits.

»I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment. I also understand that if my balance is not paid in a timely manner, my account may be submitted to a collection agency.

Patient/Parent/Guardian Signature: _____ Date: _____