

FINANCIAL POLICY

Laser Dentistry of Coeur d'Alene
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This is an agreement between Laser Dentistry of Coeur d'Alene and the patient and/or guarantor named in this form.

By executing this agreement, you are agreeing to pay for all services that are received.

Insurance: Insurance is a contract between you and your insurance company. We are not part of this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You agree to pay any portion of the charges not covered by insurance. You must inform us if you lose or are about to lose your insurance coverage. Any services rendered after insurance eligibility terminates will be charged at our standard fees.

Required Payments: We do not bill for our services. Payment is required at the time you received your dental treatment. If you have dental insurance coverage, we will estimate your insurance co-payments required by your insurance company and must be paid at the time of service. Because this is an insurance requirement, you will not be billed.

Statement: Should you end up with a balance on your account due to underestimation of your insurance co-payment, we will send you a statement. It will show the charges to the account.

Payment Options:

1. You may pay by cash, check or credit card on the day treatment is rendered.
2. For charges of \$300 or more, a 5% fee reduction will be extended for full cash payment in advance for non-insurance covered procedures or for patients with no insurance.
3. On extensive treatments plans you may prefer to secure a third party financing option for your out of pocket expenses. We offer special financing through Care Credit and Dental Fee Plan. You can ask about the no interest options.

Returned Checks: There is a fee of \$25.00 for any checks returned by your bank. Returned checks not redeemed within 21 days will be turned over to collections and associated fees will be added to the balance due.

Missed Appointment Fee: The second time a patient does not show up on time for an appointment, or cancels with less than the required courtesy notice of 24 hours, a fee of \$50 will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

The Financial Policy continues on the back side of this page. Please read both sides carefully before signing.

Patient's Name: _____

Signature: _____ Date: _____

Responsible Party: _____

Divorce: In case of divorce or separation, the parent accompanying the child and authorizing treatment will be the parent responsible for the charges on the day of service. If the divorcee decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge: Patient and /or account guarantor are fully responsible for the total payment of all procedures completed. All services are due to be paid in full within sixty (60) days of the date of service, regardless of whether or not insurance benefits have been received. One and one-half percent (1.5%) per month interest (18% per year) will be charged on accounts 60 days from treatment date.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency or to an attorney, you agree to pay all collection costs, including attorney fees plus all court costs which are incurred. In case of suit, you agree that the venue shall be in Kootenai County, State of Idaho.

Credit History: If you default on your account, we have the option to report your account status to any credit reporting agency such as a credit bureau.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transfer of Records: You must make a request in writing to obtain copies of your records. Your request will be processed no earlier than five (5) business days but no later than ten (10) business days from the time we receive your request. You authorize us to include all relevant information, including payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information including your payment history.

Emergencies: All workers compensation related claims and personal injury claims, regardless of insurance coverage are to be paid in full by cash or credit card only.

Co-signature: If this or another Financial Policy is signed by another person, that co-signing remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

We are here to assist you in any way possible. Please make your questions and concerns known to our team.... Our goal is to ensure that you have an outstanding experience with us.