

VALLEY DENTAL GROUP

FINANCIAL POLICY

Thank you for choosing Valley Dental Group for your dental health. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of financial policy, which we require that you read, and sign prior to any treatment

PAYMENT

- ∴ Full payment is due at time of service
- ∴ We accept cash, checks, Visa, MasterCard and Discover
- ∴ Dental Fee Plan (Credit you can apply for over the phone or online)

INSURANCE

You are required to pay deductible and a percentage that insurance does not cover at time of service. We do accept assignment of insurance benefits and will be happy to submit a claim form to your insurance company for you. We cannot bill your insurance unless you bring all insurance information and if needed an original claim form. Your insurance policy is a **contract between YOU and your insurance company**. We are not party to that contract. We provide administrative services in collecting from your insurance company. You are responsible for all costs for dental care whether covered by insurance or paid directly by you. Our office strives to provide quality, dependable, and esthetic dental care. The least expensive insurance solution is seldom in the best interest of your health. It is important to understand that insurance companies draw all contracts with your employer. Their plan may not fit your overall dental health requirements. *Insurance companies can and do apply clauses that limit their level of coverage, placing sole payment responsibility on the patient.* If a problem arises, our front office staff may suggest some steps towards improving your dental plan. Any balance owed after Insurance pays is your responsibility. If your insurance company has not paid your account in full within 45 days, the balance then is your responsibility. Please be aware some and perhaps all of the services may be noncovered services under your insurance policy. Secondary insurance is submitted after primary Insurance payment has been received.

USUAL AND CUSTOMARY RATES (UCR)

Our practice is committed to providing the best treatment for our patients and our fees are competitive for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of UCR.

PRE TREATMENT ESTIMATE

We will estimate the insurance portion and the patient portion of charges to the best of our expertise. This is an approximate computation of probable cost and does not guarantee payment by your insurance company. You are ultimately responsible for full payment.

MINOR PATIENTS

The adult accompanying a minor and the parent (or guardian(s)) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan.

MISSED APPOINTMENTS

Unless canceled at least 48 hours in advance Monday through Friday, our policy is to charge for missed appointments a minimum of \$45.00. Please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our Financial Policy Please let us know if you have any question or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy

Signature of Patient or Responsible party

Date