DENALI DENTAL ASSOCIATES, LLC

FINANCIAL POLICY

Thank you for choosing our office for your dental treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment in our office.

Unless specific billing arrangements are made at each visit, payment for services is due at the time of service. We accept cash, check, Visa, MasterCard, Discover and Care Credit. **Please be advised:**

- Your Dental Benefit Plan is a contract between you, your insurance company and (possibly) your employer. As a courtesy to you, we will bill your insurance company for you.
- Insurance companies often set reimbursement schedules that are lower than our usual and customary charges. You may still be responsible for the full amount of our charges.
- You may receive services that your Dental Benefit Plan does not cover or pay for. You will be responsible for these charges.
- In the event a check is returned back to Denali Dental Associates due to NSF, a returned check fee of $25.00 will be added to your account.

MISSED APPOINTMENT FEE: any appointment cancelled or broken with less than 24 hour notice may be charged a $50.00 cancellation fee per hour scheduled.

By signing below, you are agreeing to our policy and authorizing the release of information to your insurance company so they may pay Denali Dental Associates, LLC directly.

If for any reason we have not received payment from your insurance company within 60 days from your date of service, you become responsible for the outstanding balance. At 90 days, any outstanding balance becomes subject to collection. If your account is sent to an outside collection agency you will be responsible for any legal fees, court costs, and/or collection fees incurred in the process.

I have read, understand, and agree to this financial policy.

Signed:______________________________ ______________________________

Patient or Responsible Party Signature **Patient or Responsible Party Printed Name**

COMMUNICATIONS

From time to time it may be necessary to leave messages for patients concerning appointments, insurance questions, or other issues or concerns. Please indicate by initialing each form of communication which we may leave messages:

Answering Machine ______ Cell Phone ________ E-Mail ________

NOTICE OF PRIVACY POLICY – ACKNOWLEDGEMENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form acknowledging receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. By signing below, you are authorizing the release of information for different purposes, including treatment, payment, and healthcare information.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

______________________________ _______________

Signature Date

I am also signing for my minor children:________________________

I give consent for my treatment to be discussed with the following individuals (e.g. spouse, parent, adult child)

Name & Relationship

1901 Airport Way, Suite 103 Fairbanks, AK 99701 (907)452-1737