OUR FINANCIAL POLICY

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company.

As a courtesy to you we will continue to help process all your insurance claims. In order for us to help our new patients, you must bring a completed dental insurance form or proof of insurance to your appointment . **ALL CLAIMS NOT PAID WITHIN 60 DAYS WILL BECOME YOUR RESPONSIBILITY.**

We require that you pay your copayment and deductible at the time you receive treatment. In some cases, your insurance company will require you to pay us for the full amount to be reimbursed to you directly by your insurance company. Please ask the front desk for the above mentioned carriers.

Please be aware that some, and perhaps all services provided may be non-covered services and not considered reasonable and necessary under insurance plan.

Balances older than 30 days are subject to finance charges of 2% per month (24% annually). There is a charge of $35 for any checks returned by the bank. This disclosure is in compliance with the Truth-in-Lending act.**If you should have a balance with our office we offer 60 days to pay the balance in full. If you are unable to pay your balance within the time frame, please contact our office to make arrangements. Please be advised, if your account with us is sent to collections,35% will be added to your balance.**

Unless canceled at least 24 hours in advanced, our policy is to charge $50 for missed appointments. Please help us serve you better by keeping your scheduled appointments.

Patient_____ Date_____

Responsible Party_____ Date_____
(if minor)

For our patients with insurance:

Please sign below so that we may keep your signature on file in order to submit Insurance claims for you. **We are not in network and do not participate with ANY insurance company,whatever is left over after insurance is your responsibility.**

I have reviewed my treatment plan.

I hereby authorized payments to Pinnacle Dental Group

I authorized the release of any information relating to them claim.

Group of the insurance benefits payable

Signed_____