FINANCIAL POLICY:

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. 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. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. Any difference in payment from your insurance company and your account balance is your responsibility.

Insurance assignment: Insurance benefits are estimates only. I understand I am responsible for any co-payments and deductibles, as well as any procedures not covered by my insurance company. I authorize payment directly to Prestige Dental Center/Prestige Denture Clinic. I understand I am responsible for all costs of treatment. I grant the right for Prestige Dental Centers/Prestige Denture Clinic to release my dental/medical histories and other information about my dental treatment to third party payers and/or health practitioners. If a bill is unpaid 90 days or more, a collection agency will be used and I will be responsible for all collection costs and legal fees accumulated on my behalf or that of my dependents.

Appointment cancellations with less than 48 hrs notice or failed appointments will have a $50 charge for an appointment with a hygienist and a minimum of $50 with a maximum of $300 for an appointment with a dentist, depending on the length of the appointment. (Cancelations due to weather will not be charged)

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a charge of 1.5% per month interest. I am responsible for all collection costs insured by the dental office and on a returned check, a fee of $30.00.

PLEASE NOTE ***<u>Divorced Parents:</u>*** The parent who is present with the patient at time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.

Signature of Patient or Responsible Party:____________________________ Date:__________

MEDICAID PATIENTS: I understand I must submit my current Medicaid identification card along with a picture ID on the day service is rendered.

I am aware that I am financially responsible for services not covered by the Colorado Medicaid Dental Program.

Colorado Medicaid Dental Program has a maximum of $1000 for adults 21 years of age and older. I am aware that I am financially responsible for any services that exceed the $1000 maximum.

I also understand after Medicaid has processed the claim there may be a portion of the balance which will be my responsibility. I agree to pay this balance within 30 days.

____

Member Signature   Date

____

Parent or Guardian Signature (if the member is under the age of 18)   Date