ASCENT
FAMILY DENTAL

Scott Williams, DDS

FINANCIAL POLICIES

So we may confidently provide great dental care we require all fees to be paid at the time care is rendered. Payment for our services may be in the form of cash, check, MasterCard, Visa, American Express or Discover. We also accept CareCredit.

As a courtesy, we will submit a claim to your dental insurance in your behalf. We file all insurance claims electronically. We are not responsible for how your insurance handles claims or what benefits they pay on a claim. We can assist you in estimating your portion of the cost of treatment. Your insurance company is required by the Colorado Insurance Commissioner to process, pay or reject all insurance claims within thirty (30) days. You are responsible for any balance on your account after insurance pays or if they choose not to pay.

With your signature you authorize payment directly to Ascent Family Dental for all insurance benefits. You also authorize Ascent Family Dental to release required information to any dental specialists or other health care professional involved in or consulting on my treatment.

Any **balance exceeding (60) days** in age may be forwarded to a collection agency and/or attorney. All costs incurred in collecting unpaid fees will be charged to your account.

A $50.00 fee will be assessed for a "returned check(s)".

APPOINTMENT POLICY

Our goal is to provide quality, individualized, dental care in a timely manner. "No-Shows" and last minute cancellations inconvenience those individuals who need access to dental care in a timely manner. Our office policy regarding missed appointments enables us to better utilize available appointments for our patients in need.

Please be courteous and call the office within a minimum of 48-hour notice if you need to cancel or reschedule the time that has been allotted for your dental care. Failure to do so will result in a $50.00 fee assessed on your account for any appointment missed without adequate notice. We do not allow repeated cancellations or short-notice changes.

I have read the above financial policy and understand my financial options and obligations as described.

_____

Signature of Patient/Responsible Party Date

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVARCY PRACTICES

"You may refuse to sign this acknowledgment"

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Signature Date

Permission

- ☐ Yes, you may use my testimonial, photos and video and name to let other patients know about my great experience with your office or for educations purposes.

_____

Signature Date