

Patient's Name or Guardian: _____

Welcome to **Colorado Endodontic Specialists, Inc.**! We would like to thank you for choosing our office for your dental care. Please be advised that in order to provide the highest quality dental care in a safe and comfortable environment without exceeding any inconvenience to you, it is necessary to define our office financial agreement before any treatment commences. If you have any questions, please do not hesitate to ask.

1. Appointments are kept as accurately as possible, unless there are emergencies. Please try to understand if you are asked to wait for the doctor.
2. Accurate medical history, limited evaluation/consultation and a signed consent form are needed before any treatment can begin.
3. Payment is due at the time of service. We accept Visa, MasterCard, Discover, American Express, and personal/business check service through TeleCheck. We also offer a third party financial service for any patients who qualify and would like to take advantage of a 90 day no interest payment plan or extended financing.
4. For Patients with dental insurance coverage:
 - Benefit description is provided only with the subscriber's ID or social security number, date of birth, employer group name or number, and address. **Please understand that an estimate of Patient responsibility is just that and cannot be guaranteed.** Benefits are determined at the time a claim is processed or settled.
 - Our office requires payment in full for new evaluation/consultation visits. As a courtesy, a claim will be filed on your behalf. Any benefit will be sent directly to you from your carrier.
 - At the time of your treatment, your estimated Patient responsibility is the deductible, co-payment and any difference of fees. A claim will be submitted. With any unpaid balance after a claim has been settled, a statement will be sent to you and the balance will be due upon receipt.
 - For your convenience, if the balance due after your claim settles, our office will process the credit card used at the time of treatment for the outstanding balance with your authorization. We will then issue a card receipt and statement to you. _____ **Signature**
 - If there is an over payment by you after your claim has been settled, a refund check or credit will be issued. Refund checks are processed and mailed once each month.
 - If there is dual dental coverage, our office is limited to two policies and the primary coverage will be honored accordingly to contract if applicable. An estimated patient responsibility will be calculated based on your primary benefit description. A secondary claim can only be submitted once the primary benefits and EOB have been received. (From past experiences, this process may take anywhere from one to six months.)
 - Insurance benefits are a contract between you and your employer. The amount of coverage you will receive depends on the plan purchased by your employer, not the fees of the doctor.
 - Please understand that our office is limited in accessing information from your carrier and the processing of claims. It is the responsibility of the Patient to handle insurance issues accordingly.
 - Regardless of insurance, our office cannot carry balances longer than 90 days from the date of service. If no response or payment has been received from your carrier, we ask that you pay for your account.
 - We regret that we are unable to file claims with medical insurance companies. However, we will be happy to provide you with the information necessary and assist with filing your medical claim.
5. Delinquent accounts are defined by the following characteristics: claims have been settled, statements have been generated, and payments have not been received within 10 business days or payments are not received and posted for the same day of service. These accounts are subject to late and/or collection fees and services. Due to the cost of processing, a statement fee of \$2.00 may be assessed on any statements.
6. We reserve the right to assess a fee of \$75 for missed appointments or cancellations with notice of less than 48 hours.
7. For guests under the age of 18 years, a parent or guardian must be present at the appointment and is responsible for payment regardless of what a divorce decree may state.
8. We strive to provide a relaxing environment to our patients. To ensure that all patients are able to enjoy the same experience, we ask that you step outside to speak on a cell phone. We also request that children and pets do not accompany you to the office, as we are not able to provide adequate supervision during the treatment process.

Authorization:

I have read the above policy and accept the responsibility set forth regarding my account with Colorado Endodontic Specialists, Inc. In signing this document, I also authorize Colorado Endodontic Specialists to release any information concerning my case to my insurance carrier or care provider.

Signature of Patient (or Guardian if under 18 years old)

Date