Financial, Insurance, and Missed Appointment Policy

1. If You Are Covered By Insurance

As the patient receiving the benefit of treatment, you (or your "responsible party") are ultimately financially responsible for all dental services received, regardless of your insurance coverage. Insurance is a contract between you and your insurance company and our office is not a party to that contract. Our practice does not guarantee that your insurance company will pay for treatment you receive. As a courtesy, our office may assist with pre-authorizations and help to file your insurance claims. However, even though we are filing these claims in your behalf, we do not accept responsibility for the outcome of these transactions. The responsibility for full payment remains with you as the beneficiary of the services. If payment is not received from your insurance company within 60 days of the date of service, you will be expected to pay any outstanding balance in full.

Patients with insurance are expected to make a down payment (co-payment) at the time of service. This down payment amount is based on our experience and is merely an ESTIMATE of the portion that will not be covered by your insurance. After your insurance pays its portion of the claim amount, this down payment (co-payment), may be found to be insufficient to cover the remaining balance. You will then be responsible for payment of the balance. Similarly, any overpayment will be refunded to you.

2. If You Are Not Covered By Insurance

Patients without insurance are expected to make payment in full for all charges at the time of service unless prior financial arrangements have been made. Financial arrangements with our office must be made in advance of treatment.

3. Payment Options and Considerations

Payments may be made with VISA, MasterCard, Discover, CareCredit, debit card, cash or personal check. A $30.00 service charge is assessed on all checks returned unpaid by your bank. A service charge of 1.5% per month (18% annually) will be assessed for account balances that extend past 60 days. Charges for mailing statements may also apply.

Delinquent accounts (over 90-days due) will be referred to a collection agency at our discretion. If a collection referral becomes necessary, the undersigned aggress to pay all costs including reasonable attorney fees to effect payment. By signing this agreement you give permission to our office to telephone you at home or at work to discuss matters related to this form.

4. Insurance Authorization

With my signature below, I hereby authorize release of any relevant information necessary to process my claim to my insurance company. I also authorize any insurance benefits otherwise payable to me to be paid directly to David W. Larsen DMD LLC for services provided.

5. Deposit Policy

For some procedures, a deposit may be required to reserve the appointment time. In the event of a "missed appointment" without 48 hours notice, the deposit will be forfeited and will not be applied to any other treatment fee.

6. Missed Appointment Policy

Your scheduled appointment is a reservation. Our office reserves the appointment time just for you. If you need to re-schedule an appointment, we ask that you provide 48-hours notice.

A "missed appointment" is defined as not arriving for a scheduled appointment, cancelling an appointment with less than 48-hours notice, or arriving more than 10 minutes late. Patients who repeatedly miss appointments, increase the cost of providing healthcare to everyone and jeopardize their professional relationship with our office. Our missed appointment policy follows:

- After two "missed appointments" (in a 24-month period) in which 48 hours notice has not been given, you may be charged a $25 fee or the office may require you to pay a deposit before we reserve your next appointment. The deposit fee will be applied to any treatment rendered, or forfeited if your reserved appointment is "missed."
- Appointment Reminders: As a courtesy to our patients, our office will generally send confirmation post-cards or email notifications to patients two weeks prior to a re-occurring hygiene appointment. If the appointment time needs to be re-scheduled, we ask that call our office to make the scheduling change with at last 48 hours' notice.

7. Acknowledgement

This policy form represents an agreement between you as the patient and our office. It is intended to facilitate our ability to provide excellent service to you while minimizing administrative expenses. I acknowledge that I have read this agreement and agree with it.

_____ _____

Signature - Patient/ Responsible Party Date