MOUNTAIN LOOP
DENTAL

OFFICE FINANCIAL POLICY
David Gore, DDS

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options. Please let our office know if you have any questions. We are happy to discuss this policy to ensure that you have an outstanding experience.

We offer the following options

- Cash, Check, Debit Card
- Visa, MasterCard, Discover, American Express
- Payment Plan – short and long-term financing, upon approval

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your individual plan, plan benefits and coverage must be address and answered by your insurance carrier.

AUTHORIZATION AND RELEASE

I authorize payment to be made directly to Mountain Loop Dental by my insurance company. I authorize release of my medical/dental care information requested by my insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office in accordance with their regular fees and terms. I understand that any balance, not covered by insurance, is due at time of service for all services rendered. _____ initial

Furthermore, I understand that all services are due to be paid within sixty (60) days of the date of service, regardless whether or not my insurance benefits have been received. A finance charge of .75% per month, nine percent (9%) per year will be charged to unpaid balances until paid in full.

I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____
Responsible Party Date

_____ _____
Financial Coordinator Date

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