



1201 S Elk Street
Casper, WY 82601
Phone: (307) 234-3890
Fax: (307) 472-5583

FINANCIAL POLICY

Our top priority is to provide you with the best dental health care possible, regardless of your insurance situation. With so many different dental plans available to our patients, we cannot be responsible for knowing the details of the coverage for each of them.

It is the policy of our office that payment for dental services is due at the time services are rendered. When appropriate, and in accordance with your insurance plan, we will request co-payments, deductibles and/or co-insurance amounts at the time of service. We will submit all claims to your insurance company as a courtesy. Our submission does not guarantee payment from your insurance company.

We offer a variety of convenient payment options. We accept cash, checks, Visa, MasterCard, Discover, American Express, and CareCredit. If a credit card payment is made by phone your signature below will grant our office permission to process the payment. Charges unpaid after 120 days are delinquent and maybe placed with an outside agency unless you have a signed payment agreement with us. Should my account be referred to an attorney or collection service for nonpayment, I agree to pay reasonable attorney fees, costs, and collection expenses. Additionally, any return checks will be subjected to a fee of \$35.

We kindly request a minimum of 24 hours notice for any appointment changes, including canceling or rescheduling an appointment. If you cancel or no-show an existing appointment without 24 hours notice you will be charged a \$52 fee and it must be paid prior to being seen at your next appointment.

I have Read and understand the above financial policy for Signature Dental and I agree to the terms and condition specified.

Patient Name (printed)

Date

Patient Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hear by acknowledge that I have given the right to review the notice of privacy practices of Signature dental parentheses HIPAA. Please notify the front office if you would like a copy of this document. I understand that my protected health information may be used in disclose for the purposes of treatment, payment, and healthcare operation of the practice.

Patient Name (printed)

Date

Patient Signature