Castle Peak Dental
56 Market St., Suite 5, Eagle, CO 81631
970-328-1116

Patient Financial Policy

Thank you for choosing Castle Peak Dental! We look forward to serving you and are committed to providing you with an exceptional level of care and attention!

Your clear understanding of our Patient Financial Policy is important for our professional relationship.
Please read carefully and initial after each section, then sign and date at the bottom.

Dental Insurance

- We participate with many insurance plans and we want to maximize your benefits.
- We will do our best to gather your insurance information and provide accurate estimates based on the information we have been provided.
- Due to increased hold times and difficulty of attaining plan information for providers you may be asked to call your insurance company to find out the network status and coverage.

Complete Dental Insurance Information is Required 48 Hours Before your Appointment

- Dental insurance information must be submitted complete and accurate.
- If we do not receive the information at a minimum of 48 hours before your appointment, the options are to pay in full for your visit or to reschedule.

We will Submit your Dental Claims as a Courtesy

- If your claim is denied, we will follow up and appeal on your behalf.
- We cannot accept responsibility, control, or guarantee any payment from your insurance company.
- You are responsible for the total financial obligation for all services and/or procedures rendered.
- Outstanding insurance balances after 60 days will be billed to the patient.

Initial_____

Treatment will be Based on what is BEST for you and your Health

- We will create and review treatment plans as needed, based on what is BEST for you and your health and not what your insurance will cover.
- Procedures and prices will be based on your CURRENT dental health and are valid for 90 days.

Initial_____

Payment is Due at the Time of Service

- Payment options: Cash, Check, All Major Credit Cards and Care Credit.
- A 10% courtesy discount is available for patients without insurance on a balance paid in full on the date of service (cannot be combined with Care Credit or Loyalty Member Program).
- In-House Loyalty Member Program available to patients without Dental Insurance for a small yearly membership fee.
- Returned check fees of $25.00 will be applied to each returned check.

Initial_____

Outstanding Balances

- Accounts that reach 90 days past due, with our attempts to collect unresolved, will receive 1 final letter with a date stated to pay the account in full. If no resolution is made, the account will be sent to our collection agency with possible discharge from the practice.
- If the account is turned over to collections, the person financially responsible for the account will be responsible for all collection fees, including but not limited to attorney's fees and court costs.
- In the event a legal suit is necessary to enforce payment of the account, the person financially responsible for the account will agree to pay for all attorney and/or court fees.

Initial_____

Late and Cancellation Policy

- At Castle Peak Dental, we value your time.
- To ensure all patients receive quality care, we ask you arrive to all appointments 10 minutes prior to your scheduled time.
- If you arrive more than 10 minutes late, we may not be able to complete all treatment that was scheduled.
- If it is necessary to cancel an appointment, please do so with a minimum of 48-hours advance notice.

Initial_____

Privacy Practice Policy

I hereby authorize payment directly to Castle Peak Dental from the insurance benefit provider otherwise payable to me. I grant the right to Castle Peak Dental to release my dental history and other pertinent information about my dental treatment to third party payors.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name

_____

For Parents of Minor Children

I hereby authorize the following individuals to bring my child to and from appointments and have indicated if they have authority to authorize treatment or any changes in treatment plans along with financial arrangements for my child

_____ _____ Can Cannot authorize treatment or treatment changes

Name Relationship

_____ _____ Can Cannot authorize treatment or treatment changes

Name Relationship

_____ _____

Signature of Patient or Responsible Party Date

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