ASSOCIATES IN PERIODONTICS
periodontics and dental implants

1120 East Elizabeth Street, G4
Fort Collins, CO 80524
(970) 221-5050

APPOINTMENT & FINANCIAL COMMITMENT

Thank you for choosing our office for your dental needs. Please read the following information carefully. If you have any questions, please direct them to our Insurance Coordinator.

Dental treatment is an excellent investment in an individual's well-being. Financial concerns should not be an obstacle in obtaining this important care. We recognize that many people are concerned about the affordability of dental care. Therefore, we are happy to provide several payment options.

To best meet the needs of our patients, Associates in Periodontics is an "*On Time Dental Practice"*. When we schedule an appointment for you, two events occur:

1) We will reserve that appointment time for you in our appointment book
2) We trust that you will arrive on time for that appointment.

If you are late for an appointment, we will do our best to fit you in our schedule, however, it may be necessary for us to reschedule your appointment. We will likewise do our best to remain on time however, please keep in mind that we are a surgical practice and circumstances beyond our control can arise so your patience and understanding are appreciated.

Please note that appointments rescheduled or cancelled less than 24 hours before their schedule time may result in a fee in the amount of 40% of the scheduled procedure. Three or more failed appointments may result in your dismissal from the practice.

Office Hours

Monday - Thursday	8:00 AM – 5:00 PM (12::00 – 1:00 PM closed for lunch)
Fridays	Closed

Should you have appointment needs, concerns or questions regarding your account, please do not hesitate to contact us.

As a condition of treatment by our office, all fees are due and payable at the time of service.

We accept credit cards (Discover, Visa, and MasterCard), debit cards, cash and personal checks ($50 fee for returned checks). For your convenience, we also accept Care Credit. Please speak to our Insurance Coordinator for information regarding this outsourced financial plan.

Please initial after each statement to acknowledge that you have read and understand the following:

1. In-Network Insurance and how we work with these companies

We are contracted with **Aetna, Anthem Blue Cross Blue Shield, Delta Premier, Delta Dental PPO, MetLife, Principal, and United Concordia**. We will gladly process your insurance claim to help you receive the full benefits of your coverage as a courtesy to you. However, you must complete the insurance section of our New Patient Form in its entirety. We will send a request for pre-authorization/ pre-estimate for procedures other than maintenance cleanings but trust that you will check with your insurer to find out the details and/ or limits of coverage. It can take 1-4 weeks to hear back from your insurance company so we will try to schedule your appointments accordingly. We cannot make any guarantee of estimated coverage or payment but please know that we will do everything possible to see that you received the full benefits of your policy. The estimated amount not covered by your insurance may be paid by one of the following payment options and we will be happy to work with you to plan the most appropriate arrangements for your budget.

Please be aware that **we are not a Medicaid/ Medicare provider**. This also includes plans that are driven by either program. Delta Dental CHP+ and any Delta Dental Medicare Plans fall under this category. As part of our Opt-Out agreement, we must

inform you in advance that we will not bill Medicare nor will you be able to submit a claim for reimbursement from Medicare. Should you choose to have treatment in our office, you may take advantage of our other payment options listed.

Option 1: You may choose to pay for our services in full at time of service by cash, check, debit, credit or Care Credit card. We will submit all claims to your insurance as a courtesy to you and will have your insurance company reimburse you directly.

Option 2: We will **estimate** as closely as possible your portion and ask you to pay the estimated portion on the day of services. You will receive an EOB (Explanation of Benefits) detailing what amount your insurance covered and payment from your insurance comes directly to us from your insurance. If you have over or under paid, we will either send a statement requesting the balance or a refund check for the overpayment.

_____ *Patient or guardian's initials*

2. Out-of-Network Insurance and how we work with you

Out-of-network simply means that our office is not contracted with your insurance company and consequently is not obligated to accept fees according to their fee schedule. You will be responsible for paying your co-pay percentage as well as any remaining balance not covered by their fee schedule.

_____ *Patient or guardian's initials*

3. Your insurance company is required by the Colorado Insurance Commissioner to process, pay or reject all insurance claims within 30 days. We guarantee accurate filing based on the information you provide us. After 60 days, if your insurance company has not reimbursed our office, the responsibility reverts to you to be paid within 10 days of receiving a statement. If the insurance company requires any action on your part, we will contact you immediately. **Please note – our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. We charge a 1.5% finance charge per month on the balance of the account after 3 months, each time we send a statement.** Please speak to our Insurance Coordinator for any adjustments.

_____ *Patient or guardian's initials*

4. We do not automatically pre-authorize treatment, but highly recommend it. If you would like to receive an Estimate of Dental Benefits from your insurance company, please inform the Insurance Coordinator. It may take your insurance company 4-6 weeks to process the request but once we receive the estimate, we will contact you to discuss payment arrangements.

_____ *Patient or guardian's initials*

In consideration of the professional services rendered, I agree to accept responsibility for the payment of such services, and I agree to pay all legal costs including collection fees and attorney fees if I fail to pay my account. I grant by permission to you, or your assigned, to telephone me at home or work to discuss matters related to this form. I have read and agree to the above conditions.

Patient's Full Name : _____

(Please print full name - first name, middle name and last name)

Signature: _____ Date: _____ / _____ / _____

Signature of patient or guardian *mm* *dd* *yy*