KAYSVILLE FAMILY DENTISTRY

Thank you for choosing Kaysville Family Dentistry as your dental healthcare provider. We are committed to providing you with the highest standard of total dental care. We consider payment of your bill as part of this care.

PAYMENTS

ESTIMATED PATIENT PORTION IS EXPECTED IN FULL, AT TIME OF SERVICE. If your insurance issues payment to the subscriber, rather than the provider, you will need to pay in full at time of service. All emergency dental services and any dental services performed without previous financial arrangements must be paid for in full at the time services are rendered. We accept cash, checks, all major credit cards, and offer financing with CareCredit. Our financial coordinator is available to discuss any questions regarding ways to help you with financial considerations. **It is your responsibility to have this conversation prior to receiving dental work.**

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I understand that I am personally responsible for payment of all dental services. **However, should your account be turned over for collections, the undersigned agrees to pay all costs to collect the debt, including but not limited to, interest in the amount of 18% annum, attorney's fees, court costs and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency**. I further authorize you to call me at any number I provide or at any number at which you reasonably believe you can contact me, including calls to mobile, cellular, or similar devices for any lawful purpose. I agree to any fee(s) or charge(s) that I may incur for incoming calls from you, and/or outgoing calls to you, to or from any such number, without reimbursement from you.

INSURANCE

Patients who carry dental insurance understand that **all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of what insurance covers**. As a courtesy, we will prepare the patient's insurance forms and assist in making collections from insurance companies. We cannot render services on the assumption that the resulting charges will be covered by insurance. We will not become involved in disputes between you and your insurance company regarding deductibles, covered charges & "usual and customary fees", other than to provide factual information as necessary. By signing this policy, you are consenting that you have been informed of the treatment plan and associated fees. You agree to be responsible for all charges for dental services and materials not paid by your dental benefit plan, unless prohibited by law, or our office has a contractual agreement with your plan prohibiting all or a portion of such charges. To the extent permitted by law, you consent to our use and disclosure of your health information to carry out payment activities in connection with your dental claims. You hereby authorize and direct payment of the dental benefits otherwise payable to you, directly to Kaysville Family Dentistry.

MISSED APPOINTMENTS

We require a notice of 24 business hours for all cancellation or changes made for an appointment. It is important we receive this notice, otherwise a CANCELLATION FEE of $50 will be charged to your account. We do not accept cancellations over the weekend for a Monday appointment. We are aware that there may be extenuating circumstances, which we will handle on an individual basis.

MINOR PATIENTS

Either a parent or guardian must accompany anyone under 18 years of age for an initial visit. This person will be responsible for authorizing consent for all dental services and will be held financially responsible for the minor.

SIGNATURE _____ DATE_____