

# WEST VALLEY PERIODONTICS

## OFFICE FINANCIAL POLICY

*Our goal at West Valley Periodontics is to ensure that you have an outstanding experience in our office. We are committed to supporting you in understanding your dental health, so that you will always be able to make the best choices in regards to your treatment. We are here to assist you in any way possible. Please make your questions and concerns known to our team.*

**In our continued commitment to provide the highest quality dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payments.**

- \* Visa
- \* Visa Debit
- \* MasterCard
- \* Discover
- \* Cash
- \* Check (There is a \$35.00 charge for any returned check.)

**We also offer two financing options for treatment over \$300.00, which are administered for us by:**

- \* Care Credit
- \* CitiHealth Card

*Please ask our administrative staff for details and credit applications.*

- I UNDERSTAND THAT PAYMENT FOR DENTAL SERVICES PROVIDED BY THIS OFFICE FOR EITHER ME OR MY DEPENDENT, IS MY RESPONSIBILITY AND DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED.
- PATIENTS WITH DENTAL INSURANCE: I UNDERSTAND THAT ALL DENTAL SERVICES PROVIDED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR ENTIRE COST OF TREATMENT. AS A COURTESY, THIS OFFICE WILL ASSIST ME WITH PREPARING MY INSURANCE FORMS AND WILL MAKE EVERY EFFORT IN OBTAINING REIMBURSEMENT FROM MY INSURANCE COMPANY. I UNDERSTAND ANY DEDUCTIBLE AND ESTIMATED CO-PAYMENTS ARE DUE IN FULL AT THE TIME OF SERVICE.
- ONE AND ONE-HALF PERCENT ( 1.5%) PER MONTH INTEREST (18% PER YEAR ) WILL BE CHARGED ON ACCOUNTS THAT STILL CARRY A BALANCE 60 DAYS FROM TREATMENT DATE. I FURTHER AGREE TO PAY ALL FINANCIAL CHARGES, COLLECTION COSTS, 50% OF ATTORNEY FEES, AND ANY OTHER COSTS THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNT OUTSTANDING ON MY ACCOUNT.

### MISSED APPOINTMENTS

*Appointment times are reserved especially for you and it is a bond of trust between you and our office. In helping us to serve you better please keep your scheduled appointments. Our time is dedicated to high quality services at reasonable costs. In order to deliver this to all of our patients, we ask that you choose a time that you will be committed to. It is important that you notify us at least **24 hours before** your appointment if you need to cancel or reschedule. We reserve the right to charge a \$35.00 missed appointment fee for broken/missed appointments*

\_\_\_\_\_  
PRINTED NAME OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT/GUARDIAN

\_\_\_\_\_  
TREATMENT COORDINATOR