GLACIER LAKE DENTAL

Financial Policy

Thank you for choosing Glacier Lake Dental for your dental care! We are committed to your successful treatment. Please read our office policies carefully and sign at the bottom to proceed with your appointment.

Payment

Payment for our services is due at the time of your visit. We accept cash, personal checks, and major credit cards. For payments exceeding $300, we also offer interest-free financing options through CareCredit, a third party healthcare financing organization.

Insurance

If you have insurance coverage, we can process the insurance claim for you, and give you an estimate for the patient portion of your bill. This portion is due at the time of service. If we do not receive payment from your insurance company within 45 days, or if the insurance coverage is less than we estimated, we will send you a bill for the outstanding amount. If we overestimated the patient portion, we will promptly send you a check for the amount you overpaid.

Late Payments

In the event your account becomes past due, we will assess a late charge equal to 1.5% per month of your outstanding account balance. If your account becomes overdue by more than 90 days, it will be referred to an outside collection agency. You will then be responsible for the collection costs incurred by Glacier Lake Dental in collecting the payment.

Returned Checks / Insufficient Funds

Checks that are returned as a result of insufficient funds or an account being closed or suspended, will be assessed a $15 processing fee.

Correspondence

Glacier Lake Dental (or a person or office acting on our behalf) may contact me via mail, phone, or e-mail to remind me of my appointment, discuss my treatment, and/or my account. Reminders that do not disclose financial or specific medical information may be sent in the form of an open postcard. Correspondence that contains financial or specific medical information will be sent in a closed envelope.

Appointment Cancellation / Missed Appointment

We charge a $50 cancellation/failed appointment fee, unless given at least 24 hours notice, so we may offer the appointment time to another patient if necessary.

I have read and understand these policies,

X_____ _____

Signature of Patient or Legal Representative Date

Patient Name (Please Print): _____

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