Dale E. Colclasure, DDS

Patient Financial Policy

Welcome to the office of Dale E. Colclasure, DDS. We want to make your visit productive and enjoyable. We are happy to answer any and all questions regarding insurance plans and payment policies.

It is our policy to have a definite agreement between you the patient, and this office concerning the payment of the fees for services rendered. Prior to treatment, you will be advised of the approximate cost. For your convenience, we accept Cash, Check, MasterCard, Visa. We also have financing available through Care Credit, Dental Fee Plan, and Unicorn. All emergency dental services or any dental service performed without previous financial arrangements with the office manager, must be paid for at the time of the service.

This office reserves the right to charge $40.00 for each missed or cancelled appointment if less than 24 hours notice is given. After 2 consecutive missed appointments, it is our policy not to reschedule you for any further appointments. There is also a $25.00 charge for all returned checks for which the balance of the check and the returned check fee will be paid for in cash or money order only.

Patients not covered by Dental Insurance

Payment in full is expected when services are rendered.

Patients covered by Dental Insurance

If you are a member of a Dental Insurance Plan and have chosen us as a provider of your care, it is your responsibility to:

Provide us with information relative to your claim, including insurance card, group number, phone number for the insurance company, employer information, date of birth, Social Security number, and your address. This information is requested on the Patient Registration form, which we ask that you complete during your initial or subsequent visit.

Pay your deductible and percentage at the time of service.

Pay for services not covered by your insurance carrier.

Insurance Claims are filed as a courtesy at no charge to you. However, your insurance is a contract between you and your insurance company and you are responsible for the entire bill regardless of what your insurance company pays. We are only a third party providing the service to you. After insurance has been filed and benefits have NOT been received within 60 days from your insurance company, the entire balance becomes the patient's responsibility. A refund will be given when the benefits have been received from the insurance company. This office cannot render services on the assumption your charges will be paid by your insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for those services in full. In the event that my account is turned over to a collection agency, I agree that a collection fee of not less than 40% of my unpaid balance will be added to my account. Additionally, I agree to pay any court costs and attorney fees which may be associated with my account. I grant my permission for you to telephone me at home or work to discuss matters related to this form.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL AND OFFICE POLICY AGREEMENT.

Parent/Guardian Signature ______________________________ Date ______________