**Lone Tree Endodontics**

**Heath Parry, DMD, MDS**

**Financial Policy**

If your insurance plan is amenable to paying directly to our office, we will be happy to submit fees covered by insurance directly to your provider. We will also contact your provider prior to any treatment being performed to estimate the portion of the treatment fee which will be due at the time of service. If your treatment is not covered in our office by your insurance, or you do not have any coverage that includes endodontic therapy, full payment for services will be due the day treatment is rendered. Due to the unique nature of our specialty, we are unable to extend any in house payment plans, but will be happy to provide you with information regarding Care Credit. Care Credit is a plan that can be used to cover medical, dental, or veterinary costs and many, if not most, offices are subscribed to their plans. We accept Visa, MasterCard and Discover as well as checks (with valid identification) and cash.

Please be advised returned checks will be subject to an additional charge of $50 added to your account with our office.

Charges may also apply to requested medical reports and records as well as no-shows and appointments cancelled without 48 hours advanced notice. The latter two are charged at $50 per hour of the time reserved for your appointment.

Understand that if, for whatever reason, your insurance company denies all, or a portion of, your claim, you will be responsible for all charges associated with services rendered. Our staff is willing to make reasonable attempts to provide any and all additional information required by your insurance company, but once a claim has been denied we have no choice but to put the ball in your court.

If you have any questions regarding your account or your insurance, please contact our office at 303-484-1246 and Sofie will be happy to assist you.

ACKNOWLEDGMENT OF FINANCIAL RESOPNSIBILITY

The information I have provided to Lone Tree Endodontics is true to the best of my knowledge. I understand that I am ultimately responsible to pay for all services rendered as well as reasonable attorney and collection fees in the event of default. I also hereby authorized Lone Tree Endodontics to furnish or obtain any/all information to/from insurance carriers, referring dentists or physicians, other offices/agencies to whom we refer, or designated next of kin or caregiver concerning treatment. I authorize my insurance company to send payment directly to Lone Tree Endodontics.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_