

Lone Tree Endodontics

Heath Parry, DMD, MDS

Justin Farmer, DDS, MDS

Berit Ek, DDS

Financial Policy

Many of our patients are fortunate enough to have some coverage by dental insurance. We strive to help maximize your dental plan benefits and as a courtesy, will submit claims to your insurance company on your behalf. It is impossible to know exactly what each dental plan covers. We will collect as much information about your dental benefits as possible and determine an **estimated co-payment** to be paid on the day services are rendered. If your treatment is not covered in our office by your insurance, or you do not have insurance, we ask that payment for services be paid the day treatment is rendered

For your convenience we accept cash, checks, VISA, MasterCard, and Discover. If you would like to discuss financial arrangements, please speak with our front office team. We would be happy to set-up a financial arrangement with our office.

Please be advised returned checks will be subject to an additional charge of \$50.00 added to your account with our office.

No-Shows and appointments cancelled without 48 hours advanced notice will be charged \$100.00 per hour of your reserved appointment. Charges may also apply to requested medical reports and records.

Please 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. If a claim is denied for any reason, you will then receive a statement for any remaining balance.

If you have any questions regarding your account or your insurance, please contact our office at 303-948-4884 and we will be happy to assist you.

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

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 authorize 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 _____