MOUNTAIN RIDGE
DENTISTRY

Financial Policy

If you have questions about treatment, options, or fees, please ask for clarification before treatment begins. Our priority is to provide you with excellent dental care. Our financial policy is as follows:

Insured Patients

- Insurance benefits are a contract between the patient and insurance company. Insurance is not a contract between our office and your insurance company. We are happy to assist in filling your insurance claim and providing the details they require. **We are not, and cannot be, responsible for payment/non-payment by your insurance company. You are always responsible for balances not paid by your insurance plan.** Insurance companies always look for ways not to pay, and we are not responsible for their actions.
- If you are non-insured, or tired of dealing with insurance companies, we are happy to provide a membership plan to ensure affordable dental care is available to all community members.
- If your insurance claim is denied, full payment is due immediately. If you file an insurance appeal, you will be reimbursed pending the results of the appeal.

Payment

- We accept cash, personal checks, and most major credit cards. Payment is always due at time of service. In-house payment plans are available at your request.
- Treatments costing more than $300 require a $50 booking deposit. This deposit is applied to your treatment balance, and is used to reserve the room, chair, supplies, and team members specifically for you at the exclusion of other patients. If you prepay in full for service, this deposit will not be collected.
- You are responsible for timely and full payment of services rendered. If payment is not provided within 60 days or a cancellation violation occurs, we reserve the right to charge any card on file for payment. If we are forced to refer your unpaid balance to a collection agency, attorney, or court, you are responsible for all legal fees and costs associated.

I understand the above agreement, and agree to the terms and conditions outlined in this document.

Patient Name: _____ Date: _____

Patient Signature: _____