Northview Dental Office
5068 W 92nd Ave
Westminster, CO 80031-6302
(303)426-0023
Bert L. Moffitt D.D.S.

Financial Policies

Thank you for choosing us as your dental care provider. The following is a statement of our financial policy which we require that you read, agree to and sign prior to treatment.

Payment

We require payment arrangements at the time of service. For your convenience we accept:
_____ Payment by cash
_____ Payment by personal check
_____ Payment by most major credit cards
_____ Monthly billing to your credit card
We also offer a payment plan through Care Credit which is available upon request and approval. Please understand that payment of your bill is considered part of your treatment, and you will be expected to make financial arrangements prior to any work being performed. Please make your choice & sign_____.

Insurance

As a courtesy, we will prepare and submit an insurance claim for disbursement of benefits. We will not be able submit a claim to your insurance unless we have been given all of the necessary & current information for submission. Please remember the following information:

- The balance is your responsibility whether your insurance company pays or not.
- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.
- The fees we charge for services rendered to those who are insured are our usual and customary fees charged to all patients for similar services. Your policy may base its allowances on a fixed fee schedule which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the types of coverage they make available. Some insurance companies pay a percentage of the dental fee-for example, 40%, 80% or 90%. Some will have you pay a deductible and then payments over that amount, will be covered at a percentage rate for the remainder of your bill. Others maintain a table of allowances and pay a certain amount of your dental bill, which is then a percentage of the usual fee. Please be aware some and perhaps all of the dental services provided by Northview Dental, may be “non-covered” services and not considered reasonable and necessary under your dental contract.

Patient Portion – Your patient portion will be estimated and due on the day of service. This estimate is only an approximate amount. Patient portions which are underestimated will be billed immediately after payment is received from your insurance company. Over payments on accounts will be refunded to the patient. Account balances over 90 days will be subject to additional fees and interest charges of 1.5% per month. Checks which do not clear your bank will be assessed a $20.00 service charge for reprocessing.

Cancellations: If it is necessary for you to cancel or reschedule an appointment, we require at least 24 hour notice; otherwise, you will be charged $50.00 for the scheduled time that was missed. Because insurance companies are not responsible for and do not pay for missed appointments, you must pay for these out of your pocket.

If your account becomes past due, your signature below gives us permission to hire an attorney or bill collecting agent to collect the fees you owe for services in our office. Please, if an extenuating circumstance arise and you need to discuss your bill, talk to us promptly so that we can take that into consideration, before beginning a bill collection procedure.

_____ _____ _____

Patient Signature Print Name Date

_____ _____ _____

Co-responsible Party Print Name Date