Pineview Prescott Dental, LLC

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Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy at Pineview Family Dental.

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED.

If a procedure requires multiple appointments, payment is required in-full at the first appointment and may be asked of you prior to being seated the day of your appointment.
_____Please initial that you agree and understand.

Payment Options: 1. Cash 2. Check 3. Visa/Mastercard/American Express/Discover 4. Care Credit

Patient's with Insurance: The patient is responsible for the estimated non-covered portion, procedures and/or deductibles at the time services are rendered. For patients with insurance: the "estimated patient portion" stated above is just that, an "estimate." Your insurance group ultimately decides what to pay on your claim. While we strive to provide a close estimate of what your portion is to be and what the insurance is to pay, we cannot know for sure. If you would like for us to pre-authorize your procedure(s), please request that we do so. Fees are not guaranteed and subject to change without notice, even if your Insurance pre-authorizes procedure(s). It's important to understand, that pre-authorizations are NOT a guarantee. Ultimately, you are responsible for any remaining balance after insurance pays/does not pay. If the insurance company has not paid for the services after 60 days, we will bill you directly for the full balance We appreciate your understanding in this matter.
_____Please initial that you agree and understand.

15% annual interest is charged for any unpaid balance over 120 days. There is a $30 processing charge for non-sufficient funds or returned checks. _____Please initial that you agree and understand.

Because instruments, chairs and personnel are reserved exclusively for your appointment, there is a $50 charge per hour of scheduled chair time we have set aside for you, for changed or cancelled appointments with less than 48 hour notification. _____Please initial that you agree and understand.

Parents not accompanying their child to an appointment must make prior arrangements for payment. Parents accompanying their child are financially responsible for payment. _____Please initial that you agree and understand.

Pineview Family Dental reserves the right to refuse service for any reason/at any time. By signing this document, I hereby authorize and assign all payments and/or insurance benefits for dental services and/or surgical procedures rendered to patient, directly to Pineview Family Dental. I hereby authorize PineView Family Dental to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan and agree to these financial terms.

Signature _____ Date _____