

COLLEEN S. CARTER, D.D.S.
3955 E. Exposition Avenue, Suite 218
DENVER, CO 80209

ABOUT OUR FEES ...

We want you to feel comfortable with the dental care you receive, as well as our fees and payment arrangements. Please do not hesitate to discuss your treatment plan, fees or financial arrangements with us if you have any questions.

Payment Policy

Unless otherwise arranged before treatment, payment is expected at the time of service. There is a \$61.00 charge for all returned checks. For your convenience, we accept Visa and MasterCard.

Accounts outstanding more than 30 days from the date of treatment will bear interest at the rate of 1.75% per month or an Annual Percentage Rate of 21% per year. If this matter is assigned to a collection agency, you will be responsible for the collection charges and attorney's fees.

Insurance

We accept most insurance plans. We will work with you so that you will receive the maximum benefits you are entitled to from your insurance company.

As a courtesy to you, we are pleased to promptly submit your dental claims to your insurance company. If your insurance company allows you to assign benefits, we will accept payment directly from the insurance company. **We do require, however, that you pay your portion of the co-payment at time of service.**

Please understand that although we will submit your claims for you, the responsibility for collection from your insurance company is ultimately yours.

Payment of any amount not covered by insurance is your responsibility. If your insurance claim is not paid by your insurance carrier within 30 days of the date of treatment, we require that you pay our office and have the insurance company reimburse you.

There will be a \$61.00 fee per hour scheduled for missed appointments without 48-hour notice.

Working together ...

Our Financial Coordinator is available to answer your questions about fees, billing and financial arrangements. She is happy to respond to concerns regarding dental charges and will make every effort to arrange mutually satisfactory financial arrangements with us. Thank you.

I have read the above, understand it, and agree to it.

Signature of Patient _____

Date _____

Name: _____

(please print)

Witness _____

Date _____