ElementDental

700 W Ironwood Drive #320. Coeur d'Alene, ID 83814. 208-664-2160. www.elementdentalcda.com

Welcome
Thank you for choosing Element Dental for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

Payment
Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options:

- Cash, Checks, Visa, MasterCard, Discover and American Express
- Monthly payment plans through Care Credit.

Insurance
If you belong to a traditional insurance plan, our team can assist you by filing your insurance claim as a benefit to you. However, please be prepared to pay any patient portions and/or deductibles in full at the time of service. Your portion is estimated ahead of time for you, so you will have no question how much will be due that day. Be aware that the balance incurred at our office is your personal responsibility regardless of your insurance company's payment and coverage. Coverage amounts vary from policy to policy, and it is your responsibility to seek coverage amounts and limits of liability on your insurance policy. Please understand that your insurance policy is a contract between you and your insurance company. Element Dental holds no party to that contract and will not be responsible in the event your insurance company denies any claim.

Minors
Payment for services for the treatment of minors can be made by check, cash, Care Credit, credit card and is the responsibility of the adult accompanying that minor.

Missed Appointments
Once an appointment has been made, that time is reserved specifically for you. We reserve the right to charge a fee for all canceled or missed appointments without 48-hours notice.

Service Charges
The policy of this office is to apply an 18% annual percentage rate or a billing charge to all accounts over 60 days past due. There will also be a $40.00 fee for returned checks.

Collection Fees
Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent
The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement

_____ _____
Signature of patient/responsible party Date