MOUNTAIN VISTA DENTAL

FINANCIAL RESPONSIBILITY AGREEMENT

(Please read and initial each blank and sign full name in both places at bottom.)

This is a legally-binding agreement between Mountain Vista Dental and you as the patient. It describes your financial obligations. You must read this, initial all blanks, sign it and return it to us prior to your first treatment. The term "MVD" means Mountain Vista Dental. The terms "I", "my", "you", or "your", refer to the patient.

MVD is committed to give you the best care. In return I agree to be financially responsible for payment of MVD's services.

Acceptable forms of payment are: **1. CASH OR PERSONAL CHECK.** The office will provide a 5% courtesy on services in excess of $1500 that are paid in full prior to or at the time of the first appointment. **2. VISA, MASTERCARD, OR DISCOVER.** This allows you to make as many payments as you wish to your personal credit card company. **3. IN HOUSE FINANCING.** For patients with good credit history, the office will provide financial arrangements. These will be negotiated by the Business Manager and may be extended up to a maximum of 3 months. After 90 days a 1.5% per month (18%APR) interest charge will be assessed. If more than 3 months is required for payment, the office has a special credit card program (**CARE CREDIT)** which has no interest plans up to 18 months.

As a courtesy in our office, we will file your insurance claim for you and try to assist in any way that we can. Dental insurance is a contract between you, your employer, and your insurance company. Insurance benefits are determined by the insurance company and not by our office. We file with over 4000 dental plans; therefore, it is impossible for us to know the specifics of each one. **IT IS THE PATIENTS RESPONSIBILITY TO KNOW THE DETAILS OF YOUR POLICY, ESPECIALLY WHETHER OR NOT YOU CAN USE US AS A DENTAL PROVIDER. THIS CAN BE DONE BY CALLING YOUR INSURANCE COMPANY DIRECTLY OR CONTACTING YOUR HUMAN RESOURCE DEPARTMENT AT YOUR PLACE OF EMPLOYMENT. FINALLY, ALL DENTAL INSURANCE POLICIES HAVE A MAXIMUM THAT THEY WILL PAY OUT PER YEAR ON AN INDIVIDUAL. THIS CAN BE ANY WHERE FROM 750 TO 2000. PLEASE BE AWARE OF YOUR POLICY.**

I agree to be responsible for payment of MVD's services, regardless of whether the services are covered by your insurance and regardless of the extent of payment, if any, by your insurance. I agree to pay any balance remaining on my account for any reason after my insurance has been processed. I agree that if MVD has not received payment within forty-five (45) days of the original filing, I will be responsible for the entire account. (INITIAL:_____)

I agree to give MVD complete and accurate insurance information for primary and secondary coverage and all identification and benefit cards / documents required for claim accuracy. I understand that failure to supply complete and accurate information may result in denial of my claim or delay payment.

I agree to pay any balance remaining on my account for any reason after my insurance has been processed. (INITIAL:_____)

I understand that my insurance may or may not agree with the UCR (usual, customary, and reasonable) charges for the local area and my benefit plan may not cover all services or may even deny payment for services that have been authorized in advance. I agree to pay any balance remaining on my account for any reason after my insurance has been processed. **I UNDERSTAND THAT AN INTEREST CHARGE OF 1.5% PER MONTH (18%APR) WILL BE CHARGED ON ANY UNPAID BALANCE OVER 90 DAYS OLD.** (INITIAL:_____)

I understand that any invoice or receipt issued by MVD at the time of service is a **non-binding estimate only** and **additional charges** may apply depending upon the services rendered. I agree to pay any balance remaining on my account for any reason upon receipt of a statement. (INITIAL:_____)

If you prefer to have "exact" benefit information from your insurance company, we suggest sending a written preauthorization to the insurance company and waiting for the written results before scheduling your appointment for treatment. If financial arrangements need to be made, we suggest you set up a financial consultation appointment to go over payment options. We will be happy to work with you in any way we can. **If I choose to proceed with recommended treatment before a written preauthorization** is received from my insurance company, I know that I am responsible for any balance on my account for any reason after my insurance has been processed. (INITIAL:_____)

I understand that if my account is sent to a collection agency, I will be charged collection fees that can be up to 100% of my overdue balance. (INITIAL:_____)

I hereby authorize direct payment of dental insurance benefits to MVD. This authorization will remain in effect until revoked by me in writing. A copy of the authorization is as valid as the original .

(INITIAL:_____)

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, SURCHARGES, LATE FEES, BILLING FEES, INTEREST, ATTORNEY FEES/ AND COLLECTION AGENCY CHARGES, WHETHER OR NOT THEY ARE PAID BY MY INSURANCE. (INITIAL:_____)

Patient Signature **Date**

Print Name