

# Green Valley Dentalcare

2213 N. Green Valley Parkway, Suite 102 | Henderson, NV 89014 | (702) 547-6453

## Written Financial Policy

Thank you for choosing Green Valley Dentalcare. We are pleased to welcome you as a patient. Our mission is to deliver the best and most comprehensive dental care available by providing consistent quality care to our patients through education, communication, and superior patient service. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. To prevent misunderstandings regarding payment for your treatment, please review and sign the following financial/insurance policy.

**Payment Options:** Cash, Check, Visa, Mastercard, Amex, Discover, CareCredit

The patient is ultimately responsible for payment on the account, NOT the insurance company. We can file the insurance claims as a courtesy to our patients. The patient must pay their deductible, co-payments, and fees for services not covered prior to treatment. We make estimates regarding insurance company payments based upon information given to us at the time benefits are verified. The patient, being the policyholder, is ultimately responsible for providing the information to our office. While we do our best to collect all fees due from your insurance carrier, fees not paid by the carrier are due and payable from the patient.

Any account unpaid beyond 90 days are subject to finance charges. Accounts sent to collections are subject to a collection agency fee, finance charges and possible legal costs in addition to the balance owed. Green Valley Dentalcare charges \$25 for return checks.

At Green Valley Dentalcare we do the utmost to insure your scheduled appointment time. When you schedule a dental appointment, this time you reserved exclusively for YOU. Should you need to change your reserved dental appointment, we require a **24-business hour notification**. This courtesy allows us time to accommodate other patients. We ask for your continual help in making this courtesy policy work to better serve our patients. The fees below apply if we do not receive a 24-business hour notification:

30 min- 1 hour appointment ----- \$50.00  
1 hour appointment + every hour after ----- \$100.00

**I have read and understood the contents of this agreement.**

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient Name** (please print) \_\_\_\_\_