ALASKA COMPREHENSIVE DENTAL CENTER

PAYMENT FOR SERVICES POLICY

Please read, initial where indicated, and sign below.

PATIENT RESPONSIBILITY

Insurance coverage is not a guarantee of payment. (_____ *initial*)

We will bill your insurance if you present your insurance card(s) at the time of your appointment. It is important for you to know that **we are not contracted with your insurance carrier**. This means that you are responsible for monitoring the processes of your insurance company to make certain your claim is processed in a timely manner, for contacting them if you have questions as to how your claim was processed, and that you are ultimately responsible for payment of services rendered. (_____ *initial*)

Any co-payments or "patient responsibility" percentages must be paid at the time of service. (_____*initial*)

If we do not receive a response from your insurance company within forty-five days from the date we bill them, the balance will become your responsibility. *(_____ initial)*

You will receive a statement for any remaining balance after all applicable insurances have been applied. That balance is due in full at that time. (_____ *initial*)

We also recommend that you research your insurance benefits prior to your office visit, as there could be reasons why your insurance may not pay for your visit. These reasons might include the following:

Your deductible has not been met.

The services or procedures are not covered by your insurance. *We will inform you when we know a procedure will not be covered, but many times it is not possible for us to know with certainty, as this varies greatly among insurance companies, and because they will not make a* ***final*** *determination until they have received the claim. We will be happy to provide you with an estimate of your fees before treatment is given. You are responsible to pay for the non-covered services at the time of the visit.*

We accept cash, check, VISA, Mastercard and CareCredit. If a payment in check form is returned to us because of insufficient funds, you will be charged a $25 fee. Payment ***in full*** at the time of service is required in the following circumstances:

You do not have insurance coverage.
You have not brought your insurance card(s) with you.
You have used up your allotted insurance benefits for the benefit year.
Any cosmetic services not covered by your insurance policy.
Any procedures or treatments we believe are not covered by your insurance.

By my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them.

_____ _____

Patient Signature (or responsible party) Date

Relationship to patient if signer is not the patient:_____