FINANCIAL POLICY FORM

The fee for endodontic therapy is determined by the complexity of the tooth being treated. Therefore, we cannot give you an exact charge in advance for treatment. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. Ultimately, however, you are responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary rate.

We are happy to submit claims necessary to receive the full benefits of your coverage; however we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance we ask that all patients be directly responsible for all charges.

We accept the following forms of payment; Cash, Check, Visa, MasterCard, American Express, and Discover. In Addition, we offer CareCredit and Springstone Financial, based on credit approval, a patient payment program offering a full range of No Interest and extended payment plans

Rocky Mountain Endodontics' participates in the following dental benefit plans:

- Aetna, Assurant, Blue Cross, Cigna, Delta Dental, Metlife, United Concordia, Principle

If you are a member of one of these plans, please note the following:

- You are responsible for any co-payment amounts at the time of service.
- You are responsible for any deductibles that are not yet met.
- You are responsible for any amounts over your yearly contracted benefit amount. For example, if your total annual benefit is $900 and you have already submitted $900 of claims, you will be responsible for 100% of our fee.
- You are responsible for knowing the rules and regulations of your insurance policy. For example, not all dental or endodontic procedures are a covered benefit in all dental insurance plans.

If your account with Rocky Mountain Endodontics becomes delinquent, you are responsible for paying all costs associated with the collection procedure, and we may report the status and payment history of your account to credit reporting agencies.

I have read and understand the Rocky Mountain Endodontics financial policy, and I consent to the policy.

Patient's Name: _____

Patient's Signature: _____ **Date:** _____