FINANCIAL RESPONSIBILITY / SIGNATURE ON FILE

Our fees for services, including office visits and emergencies, are based on the level of professional skill required; the severity and complexity of your specific infection or trauma, as well as the time spent treating you. We will attempt to create an accurate estimate. If the situation arises where treatment needs to be modified, we will attempt to inform you in advance. Fees quoted are valid for 90 days.

Payment for services may be paid at each appointment by cash, personal check, VISA, MasterCard, Discover or American Express. We also work with the 3rd party financing companies, Care Credit and the Lending Club. All new patients are required to pay insurance co-payments and fees at the time of service. Payment plans may be available for individuals with extensive treatment plans.

INSURANCE: *As a courtesy to you we will bill your insurance company. If your policy involves a co-payment, the amount must be made at the time of service. If your insurance company does not respond within 30 days, the bill will become your responsibility. Any balance may be subject to 18% APR interest.*

Insurance companies sometimes use the phrase "usual and customary" when discussing physician fees. It is important that you understand that the insurance companies set their own "usual and customary" rates based on a wide geographical area and the fees we charge may differ. This is quite arbitrary as different insurance companies pay different amounts for the same procedure. It is not the policy of this office to routinely write off balances that insurance does not pay or monitor covered services and maximum benefits remaining for the calendar year. If you are uncertain of coverage, etc. you should contact your plan administrator.

Patients must realize that professional services are rendered to a person, not to an insurance company. Hence, the insurance company is responsible to the patient and the patient is responsible to us. We cannot render services under the assumption that the charges will be paid by an insurance company.

Thank you!

PLEASE READ AND SIGN: *I certify that I have read and understand the above information to the best of my knowledge. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

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Signature of Patient (or parent if minor) *Date*

I authorize PONDEROSA DENTAL GROUP to file claims on my behalf.

All payments to be sent directly to:
Ponderosa Dental Group
Dr. Dan McFarland & Dr. Scott Schroeder
2445 S 3rd W
Missoula, MT 59801