FINANCIAL POLICY

The Ultimate goal of Missoula Pediatric Dentistry, as outlined in our mission statement,is to provide quality care and be understanding of all our patients. We feel confident in our ability to provide you and your child valuable dental care which will exceed all your expectations. Our desire is to establish a long-lasting relationship with you and your child.

Our financial policy is as follows:

We require payment in full at the time of service is provided. We accept Visa, MasterCard, American Express and Discover cards, checks or cash. If you have dental insurance we will assist you in processing your claim. When the service is rendered, we will collect the portion of the invoice that your insurance does not cover. Any insurance balance over 60 days is due and payable by the responsible party.

* A fee will be charged if an Appointment is missed or Cancelled with less than 24 hours prior notice. A new appointment will not be made until the fee has been paid.

If your child requires extensive treatment, alternate financial arrangements can be made by meeting with our office manager. Long term financing options are available to those parties who qualify. These alternative arrangements must be set up in advance of treatment. We will not alter our normal financial arrangements once treatment has begun.

The parent, guardian or responsible party who brings the patient to our office is accountable for payment in full. All statements will be sent to this individual. We will not bill a third party other than insurance companies. We reserve the right to change or amend this policy at any time.

I understand that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, and all other expenses so stated elsewhere. The authorized fee of 50% and the additional costs and charges listed above represent the actual costs incurred by the holder of this note to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signers failure to pay as specified in this agreement.

* In addition there will be a $5.00 billing charge and a finance charge of .50% each month till bill is paid in full.

The signature below represents the agreement of the responsible party for this patient. Thank You very much for your compliance.

SIGN _____ DATE_____