

MESA RIDGE DENTAL CENTER  
6980 MESA RIDGE PARKWAY  
FOUNTAIN, COLORADO 80817  
[719] 392-4231

**FINANCIAL POLICY AND PATIENT AGREEMENT**

The following is the financial policy of Mesa Ridge Dental Center, which we require that you read and sign prior to treatment at our office. (For the purpose of this Agreement, the terms “you” and “your” refer to the patient or the party responsible for the patient’s care.)

**Your portion of the payment is due at the time of service.** Acceptable forms of payment are cash, personal check, and money order. We also accept Care Credit, Visa, MasterCard, and Discover for amounts greater than \$10.00. Payments not made at the time of service are considered past due when you leave the facility. A re-billing fee will automatically be charged to your account if you fail to pay for services on the date of service.

Regarding Dental Benefit Plans: As a courtesy to patients, the practice will file claims with all standard benefit plans. You are responsible for making available to the practice complete and accurate information for the filing of claims, including all identification and benefit cards and documents. **If the benefit plan denies benefits for any reason, or if no payment is received from the plan within 45 days of the date of service, you will then be responsible for paying the full amount of the bill immediately.**

The practice’s policy on accepting payments from benefit plans varies based on the type of plan, as follows:

**Indemnity Plans, & PPO Plans:** Payments received from an Indemnity or PPO plan will be applied to your account, and you agree to pay the balance. If the practice has an agreement with your carrier, we will **estimate** the portion for which you are responsible at the time of service, and payment of the estimated amount, as well as any co-payment, is required at that time. Any necessary adjustments will be made once payment is received from the carrier, and you will be billed, or your account credited as applicable.

**By signing this agreement:**

- 1) You authorize the exchange of information relating to care and claims with your benefit plan(s), and authorize payments to be made directly to the practice for services provided under your dental benefit plan agreement, which are otherwise payable to you.
- 2) You agree special financing arrangements can only be made with an addendum to this document. You agree to pay a finance charge of 1.5% per annum and rebilling charges of at least \$15.00 per billing cycle if your account is delinquent. You agree to pay costs of collections, including reasonable attorney and administrative fees if your account remains delinquent for 90 days or more.
- 3) You agree to pay a \$20.00 service fee for any check returned not paid, and understand if, upon proper Notice, such check is not paid in cash or certified funds in the time specified in the Notice, you may be responsible for three times the face value of the check or \$100.00 whichever is greater plus costs of collections, including reasonable attorney and/or administrative fees.

**PATIENT/RESPONSIBLE PARTY AGREEMENT:**

I have read and understand this Financial Policy, and agree to the terms stated herein.

\_\_\_\_\_  
Patient’s/Responsible Party’s Signature

\_\_\_\_\_  
Responsible Party’s Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient’s Name and Date of Birth