2507 6th Ave South

Great Falls, MT 59405

Phone: (406) 459-3301

Dr. Heather Moore D.D.S.

www.yourgreatfallsdentist.com

homegrowndentalmt@gmail.com

**FINANCIAL POLICY**

Patient Name: DOB:

Please read carefully and sign to acknowledge understanding and agreement

Thank you for choosing us as your dental care provider. We are committed to providing you with the best dental care available.

*Available Payment Options.*

You can choose from ~ **Cash, Check, Visa, Mastercard, American Express**

**CareCredit** payment plan option, which allows patients to finance 100% of their dental care. **NO** money down, **No** interest, **No** upfront cost, no annual fees, and no pre-payment penalties. See terms when applying.

**In-House Financing-** We offer a 90-day, in-house financing for any service over $300. Two forms of payment are required to have on file. There will be an additional 5% added to the balance that is being financed. In addition, we require half of the balance down at the time of agreement, and the remaining portion can be split into 2 payments for the following 2 months.

*Regarding Insurance.*

* **For covered services, we ask that all co-pays and deductibles be paid on the day of treatment.** Since your insurance company may not cover all costs, we ask that you pay any percentage of your balance not paid by your insurance on the day of treatment.
* **For services that are not covered by your insurance, we ask that you pay the entire fee the day of your treatment.**
* We will attempt to answer any questions we can about your insurance and, when possible we will assist in resolving complications with your insurance company. Please understand that we cannot speak on their behalf. Your insurance contract is an agreement between you, your employer and your insurance carrier. In the event that your insurance company has not paid (on your behalf), you will be responsible to pay your account.

*Patients Without Insurance.*

* **For those patients without insurance coverage, you will be responsible for payment on the day of treatment.** If you are not able to pay in full, or if your treatment requires several visits, you will be given an estimate and willbe able to discuss payment arrangements with a member of our business office Staff.
* **Membership Payment Plan-** We require two forms of payment at sign-up. Payment for all additional restorative treatment is required at the time of service.

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*Cancellation/No Show Policy.*

* Our office requires notice to cancel your appointment in the case of an emergency. **We reserve the right to charge a fee, for those not giving notice.**

*Collections*

* A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting or attempting to collect any debt owed on this account. This includes all attorney’s fees, interest and late fees.

Signature: Date