Southwest Dental Associates

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Southwest Dental Philosophy

Name _____ Birth Date _____/_____/_____

Welcome to **Southwest Dental** and thank you for choosing us as your dental provider. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policies. If you have and questions regarding these policies, please discuss them with our administrators at **208-322-5655**. We are dedicated to providing the best possible care and service to you in regards to your complete understanding of your financial responsibilities an essential element of your care.

Your dental insurance policy is a contract between you and your insurance company. We file claims as a courtesy for our patients. We will do our best to estimate coverage but that is in no way a guarantee of final payment. It is your responsibility to know the specifics of you insurance coverage and benefits.

We have made prior arrangements with some dental care plans to accept benefit assignment. Please call your insurance company prior to your appointment to determine if we are participants in your specific plan. We will submit claims to those plans for which we have a contractual agreement and will require you to pay your patient portion and deductible at the time of service. We accept VISA, MasterCard, American Express and Care Credit. We offer a 5% discount for cash and checks.

Please bring a current copy of your insurance card or print out of your insurance information and a photo ID with you to your appointment. If proof of insurance is not provided, your account will be set up as "self pay" and full payment will be expected at the time of service.

Service Terms

For the following items, please indicate that you understand by initialing on each line, then sign and date below:

_____ *Initial* In order to provide the best possible service and availability to all our patients, please call as soon as possible if you know you will need to reschedule your appointment. We kindly request a minimum of 24 hour notice and reserve the right to charge a *No Show* fee of $50.00, if no notice is given.

_____ *Initial* Not all dental plans are the same nor do they cover the same services or supplies. In the event that your plan determine a service to be a *non-covered service*, you will be responsible for the complete charge for that particular service. Payment is due upon receipt of a statement from our billing office.

_____ *Initial* There will be a $50.00 charge for insufficient funds checks issued.

I have read and understood these financial office policies and agree to adhere by the terms. I also understand that such terms may be amended from time to time by the practice.

Signed _____ Date _____