

# Financial Policy

4Eagle Dental Group PLLP  
100 Village Lane ♦ Bigfork, MT 59911  
(406) 837-4806

This is an agreement between 4Eagle Dental Group PLLP as creditor, and the Patient/Debtor named on this form.

In this agreement the words, “you”, “your,” and “yours” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we,” “us,” and “our” refer to 4Eagle Dental Group PLLP

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

**Required Payments:** Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

## Payment options if you have no insurance:

1. You choose to pay by cash, check, or credit card on the day treatment is rendered.
2. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance in three weeks.
3. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payment to the lending institution.
4. We offer Care Credit. They offer many payment options with or without interest pending on your initial payment and credit history.

## Payment options if you have insurance:

1. You must pay your estimated deductible and any out-of-pocket portions at the time services are rendered by cash, check, or credit card.
2. In the event that the insurance company’s estimated reimbursement fee does not pay the services in full, you will be responsible for any unpaid amount.
3. On extensive treatment (crowns or bridges) you may choose to pay 50% of your out-of-pocket portion on the start or preparation date, and the balance on the completion or delivery date.  
(Normally three weeks later.)

*The Financial Policy continues on the back side of this page*

Patient name: \_\_\_\_\_

Responsible Party  
(If not the parent): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co- Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

**Finance Charge:** A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one and one-half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

**Charges to your account:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

**Returned Checks:** There is a \$25 fee for any checks returned by the bank.

**Missed Appointment Fee:** If you do not show up on time for an appointment, or cancel with less than 24 hours' notice, there will be a missed appointment fee. The charge is \$50. The fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

**Past due accounts:** If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Flathead County, Montana.

**Waiver of confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Transferring of records:** You may need to request in writing, if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

**Workers Compensation:** We require written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

**Personal Injury:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

**Co-signature:** If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.