Dalen Dental Clinic

6345 US HWY 93 SOUTH | WHITEFISH MT. 59937 | (406) 862-4301

Written Financial Policy

Thank you for choosing Dalen Dental Clinic. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care. A $10.00 fee will be charged for all returned checks.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card or Citi Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Dalen Dental Clinic requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 90 days you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. Interest at the rate of 1 ¼% per month (15% annual rate) will be charged on accounts with a patient balance that is over 90 days old. It is your responsibility to obtain any pre-authorization or referrals required by your insurance carrier, and accept liability for charges should your health carrier deny benefits. Guarantor agrees to pay any insurance co-payments at the time of service as specified in the insurance policy. Also, if your insurance pays at a limited percent we request that you pay your portion of the services on the date that you receive them.

I/we authorize the release of any medical information necessary to process insurance claims for all occasions of service until I/we revoke this authorization. I/we authorize my/our health insurance company(s) to make payment(s) directly to Dalen Dental Clinic for benefits covered by my/our insurance contract.

A fee of $28.00 charged for patients who miss or cancel more than 2 times without 24-hour notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature   Date

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Patient Name (Please Print)

[1]Subject to credit approval