Patient Financial Policy

Taking care of you and your family is our highest priority.
That is why, when it comes to talking about finances, our goal is to provide you with an approximation of the total fees expected. Please understand that this will be an *approximation*. Treatment needs can change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial portion.

This agreement is to inform you of your financial obligation to our practice. When approximating insurance coverage, we must also stress that word "*approximate*" as dental benefits are determined by each patient's dental contract. Each company's dental plan is different, and necessary dental services are not necessarily covered. Most dental plans are designed to assist patients with their dental expenses. Very few dental plans fully cover all dental services.

As a service to our patients, we will file your insurance for you providing you furnish us with the current insurance information. *All charges you incur are your responsibility regardless of your insurance coverage.* We must emphasize that as your dental care provider, our relationship is with you, our patient. Your insurance policy is a contract between you, your employer, and the insurance company. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

Payment is expected at the time services are rendered unless other financial arrangements have been made in advance. All accounts with balances will receive a monthly statement. 1 1/2% interest (18% annually) is charged to all balances over 60 days. A fee of $42 will be applied to any account for a returned check.

Thank you for reviewing your payment options and indicating your choice of payment. We appreciate the confidence that you have placed in us in caring for you and your family. We are available at any time to assist you with your account. Please feel free to contact us with any questions you have regarding the payment options.

PAYMENT OPTIONS:

- ☐ **Cash or Check**
- ☐ **Credit or Debit Card**
- ☐ **Payment Plan thru Care Credit (Credit application required)**

Release of Protected Health Information (PHI)

I hereby authorize Cottonwood Dental to release my PHI as described in this authorization. I understand that my PHI may include, but is not limited to, the following: medical records, billing statements, EOB's, imaging reports, hospital notes and reports, laboratory reports, pathology reports, and any personal or medical information related to the purpose of this authorization. I also understand that this authorization pertains to ALL PHI.

Name of Person to Receive PHI	Relationship	Start Date	End Date

Emergency Contact

Please list the name and phone number of whomever you would like for us to contact in case of a medical emergency.

Name	Relationship	Primary Phone Number	Additional Phone Number

Print Name _____ Date _____

Signature _____