



Financial Policy

Thank you for choosing our office for your periodontal care. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require you read, agree to, and sign prior to any treatment.

Office Policy

Missed appointments or cancellations: In order to provide the best services to our patients, we require at least a 24 hour notice for cancellations or re-scheduling your appointments. Dr. Price's schedule is continuously full. When a patient fails to keep an appointment, other patients who need to see the doctor cannot utilize that time. Therefore, we reserve the right to charge for the short notice. More than 2 missed or cancelled appointments with less than 24 hour notice will result in prepayment for future appointments.

*We are aware that emergencies do happen so please call if this should occur.

Insurance Policy

Dental Insurance: Pikes Peak Periodontics is happy to file your dental insurance charges with your dental insurance company. Please understand that this is a courtesy and you are ultimately responsible for your account. Your insurance company may deny some or all services provided. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, deductibles and maximums which are your responsibility. If your insurance plan is not one that Pikes Peak Periodontics is a contracted provider for, our office will still file a claim on your behalf. All fees are due at the time of service. We ask that all insurance benefits be sent to you. The reimbursement for the services provided would be based upon your dental insurance coverage. Any secondary insurance must be filed by you. Our office understands the value of insurance benefits and will gladly work with you to get the maximum benefit available to you. However, it is your responsibility to provide our office with all the correct dental insurance information so we can be sure to file your claims correctly.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, Master Card, Visa, Discover and CareCredit.

I have read and agree to the financial policy of Pikes Peak Periodontics. I understand that I am responsible for payment of the balance on my account for services rendered and hereby agree to pay for such treatment.

Signed: _____ **Date:** _____

DENTAL INSURANCE

I am NOT covered by any Dental Insurance

Policy Holder: _____ DOB: _____

SS#: _____ Relationship to Patient: _____

Insurance Company: _____ Employer: _____

Member ID# _____ Group# _____

