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Financial/Office Policy

TO OUR VALUED PATIENT:

Thank you for choosing us as your dental care provider. We are committed to providing you with the best care possible. In order to achieve this goal, we need your assistance and your understanding of our financial policies. If you have any questions or concerns regarding these policies, please feel free to ask any of our staff. If you would like a photocopy of this outline, please ask.

Payment for services are due at the time services are rendered.

We accept **cash, checks, MasterCard, Visa or Discover and CareCredit (*OAC).**

We will submit insurance claims on your behalf if you show proof of insurance.

Please provide insurance card and photo I.D. (Office required SS# when using insurance) If you are not comfortable with this policy you may pay for services in full and bill your own insurance.

****If your insurance company/coverage changes, please notify us immediately.****

Please understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. **Our relationship is with you, the patient.**
2. Although we routinely try to secure payment from your insurance company by acting as the go-between, **Please remember all charges are your responsibility whether the insurance company pays or not.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
3. You are responsible for knowing your insurance benefits. Is preauthorization required for any treatment exceeding \$500? Is your insurance a **PPO** (preferred provider organization) or is it a **Indemnity Plan/Traditional plan** (can go to any doctor)? If we can be of assistance, please let us know.
4. If your insurance company does not pay in full within 30 days, we ask that you contact your insurance company to check status. After 45 days if your insurance has not paid, we ask you to pay the balance due. We expect prompt payment from you within **10 days** of receiving any statement for any balance due after your insurance pays.
5. We strive to give **accurate estimates** for treatment, But as in any treatment, unforeseen treatment can arise and the doctor will discuss this with you at that time. The estimate does not relieve you of payment for these additional services.
6. Any balance due on accounts **over 90 days** is subject to an **18 % interest charge plus any late fees.**
7. **In the event your account is sent to a collection agency, you will be responsible for any collection fees, legal fees, and court costs.** Please do not ask us to try to resolve collection problems after your account has been sent. At this point it is too late!
8. **Returned checks are subject to a \$25.00 returned check fee.**
9. A member of our staff will call to confirm your appointment, one to two days prior to your appointment. **Please confirm your appointment.**
10. **Discounts:** Senior Courtesy Discount: given to patients with **NO INSURANCE** and **OVER AGE** of 60. Pre Pay Discount: Patient paying for Treatment Plans in full before treatment begins and insurance pays patient. Providers Discounts: Insurance plans we are **(PPO)** Preferred provider organization for.

Our practice is committed to providing the best treatment for our patients. We encourage you to notify us of any changes to your health status, address, or any of the above information.

By signing : I fully understand and accept conditions of Anthem Village Dental's Financial/Office policies.

X _____
Signature of Patient

Date

I have reviewed and updated Financial/office policies.

Date: _____ Signature: _____ Date: _____ Signature: _____

Date: _____ Signature: _____ Date: _____ Signature: _____