HANSEN & AMUNDSON DENTAL GROUP, LLC

629 E. Star Ct.
Montrose, CO 81401
970.249.3330

Our Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

- All patients must complete or "Patient Information Form" before seeing the doctor.
- Full Payment Is Due At Time Of Service.
- We accept cash, check, Discover, and Visa/Mastercard.
- We offer an extended payment plan with prior credit approval

Regarding Insurance

We may accept assignment of insurance benefits. We do, however, require that your deductible and co-payment portion of the bill be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware some and perhaps all of the services provided may be "non-covered" services as outlined by your dental insurance plan.

Regardless of the insurance company's determination of usual and customary rates or amount of assignment you are required to pay the full amount charged.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minors

The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card or payment by cash or check at time of service has been verified.

Missed Appointments

Your scheduled appointment has been reserved exclusively for your dental treatment. It is the patient's responsibility to give at least 24 hours advance notice if an appointment cannot be kept. Time is of value to everyone. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding out Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the above Financial Policy.

Patient or Responsible Party____Date______________________