Taylor Family Dental
+1 (303) 838-0311 info@taylorfamilydental.com

Office Policies

Please Initial Our Financial, Cancellation, & Acknowledgement of Considerate Care Policies

FINANCIAL AGREEMENT:
I am responsible to pay up front for all of my treatment visits unless prior arrangements have been made. I understand that my dental team is providing me with **ESTIMATES** as close as possible to what insurance is expected to cover, however **I am responsible for payment *regardless* of any insurance company's arbitrary determination of benefits.** I understand no one from my dental office can guarantee payment from my independent third party insurance company.

As a courtesy, my dental office will submit claims to my insurance company on my behalf. I understand that if my insurance company has not made payment within 60 days, I will be asked to contact them myself to make sure payment is expected. I understand if payment is not received or denied I will be responsible for paying the full amount at that time. I understand balances not paid in full within 90 days of the treatment date will receive a **service charge** and be sent to a collections agency.

Payment Options:
We accept cash, checks, and most major credit cards. We also work with Care Credit so you can get the care you need, when you need it.

Insurance:
We are in-network providers for Aetna, Ameritas, Anthem Blue Cross Blue Shield, Careington, Cigna, Delta Dental PPO/Premier, Humana, GEHA, Guardian, MetLife, Principal, SunLife/DHA, United HealthCare.
We are out-of-network providers for all other insurances. If you need assistance, or have questions about your insurance policies or claims, our staff is knowledgeable and always available to help you. Our team can provide you with a complimentary benefits analysis to better understand your coverage in our office. To ensure we are able to provide adequate time with each patient, and the highest quality care, we do not participate with HMO/DMO or Medicaid plans. **By signing this agreement, I affirm I do not have any dental Medicaid coverage and will inform the office of any insurance coverage changes prior to any examination or treatment being rendered.**

Initials

CANCELLATION POLICY:
I understand that my reservation deposit will be credited back to me if I am unable to complete my treatment visit and sufficient notice is provided. I understand that missing my appointment negatively impacts our practice and other patients who are eager to complete their care. **I understand that if I do not show up for my visit, if I am more than 15 minutes late, or if I cancel without at least 48 hours notice, a $50 missed appointment fee may be assessed to my account.** I understand repeated failures will result in my dismissal from the practice. While our team understands extenuating circumstances and emergencies do occur, we ask that you call our office as soon as possible so we can clarify any misunderstandings.

Initials

ACKNOWLEDGEMENT OF CONSIDERATE CARE:
I understand my dental team is committed to providing me the highest quality care in the most comfortable environment. I acknowledge that I am entitled to considerate, courteous, and respectful treatment. I understand my dental team will ensure my appointments are scheduled within a timely manner and reasonable accommodations for emergency care will ALWAYS be provided. I understand for the safety and protection of all, security cameras are in use throughout the office which record both visual and audio input. I understand my team complies with all **ADA, CDC, & OSHA regulations** to provide a clean and safe environment for all dental visits. I understand I may seek a second opinion at any time and request a copy of my digital X-

rays WITHOUT incurring any additional fees. I understand that I am entitled to **privacy** and **confidentiality** in discussions, examinations, and treatment.

Initials

Patient/Guardian Signature:

_____

Date: _____