Financial Policy

Thank you for choosing Peak Dental.

Below is detailed information on our practice's financial policy.

If you have dental insurance.

As a courtesy, we will file your dental insurance claims for you and accept assignment of payment to our office. It is still your responsibility to know the terms of your own policy. At the time of treatment, you will be responsible for paying the estimated difference between our fee and the insurance company's allowable fee for each procedure performed on you. We currently accept all private care insurance plans (these are the plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). We do our best to maintain computerized histories of payment from a given company, however they do change their allowable fees from time to time. With this being said, it is impossible to give you a guaranteed quote prior to, or at the time of service. We estimate your portion based on the most current information we have. THIS IS ONLY AN ESTIMATE. If your copay is underestimated, you are ALWAYS responsible for the remaining balance on your account.

Payment Plans

We understand that there are times in which you will not be able to pay in full at the time of service. In this instance, we can offer Care Credit as an option. If you plan on utilizing this solution, you must make arrangements prior to the appointment. You can register online at CareCredit.com; our staff would be glad to assist you in our office. After using this account, you will be billed in monthly installments from Care Credit at the terms you agreed upon with them. They will provide your payment options before choosing your plan.

Collections:

If by chance a remaining balance cannot be collected, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of up to 25% of the debt.

Authorization:

By signing below, you indicate that you understand that you and you alone are solely responsible for your account and that you agree to pay for your treatment (along with any treatment for any children or other parties you may be responsible for at time of service.

Printed Name: _____

Patient Signature: _____

Date: _____