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### Office Policy

We, the staff of Shores Family Dentistry, thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship. Our goal is not only to inform you of the provisional aspects of that financial policy, but also to keep the lines of communication open regarding financial issues. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact the office.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, **payment for services are due, in full, at the time of service. Any payment arrangement must be approved in advance by our staff.** Account balances over 90 days past due are subject to collection proceedings.

We make payment as convenient as possible by accepting cash, checks, CareCredit, and all major credit cards. A \$35.00 service fee will be charged for all returned checks.

**Insurance** - Please remember that **your insurance policy is a contract between you and your insurance carrier.** We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. A preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is a participating or non-participating provider with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. **When insurance is involved, we are contractually obligated to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.**

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our standard fees will be charged for services, unless there is an applicable contract with your carrier.

**Missed Appointments** - We require notice of cancellations 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance, a minimum missed appointment fee of \$75 will apply.

**Children in the office** – Please make arrangements for your non-scheduled children prior to your visit. Children should not be left unattended in the reception area. All children, 17 years of age and under, scheduled for treatment must have a parent or legal guardian present in the office during their visit, or a signed consent for treatment.

We reserve the right to dismiss any patient from our practice for excessive missed/rescheduled appointments, failure to pay for services or for inappropriate conduct in our office or on the phone.

I have read and understand the Shores Family Dentistry office policy.

Print Patient Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_