Aspen Endodontics

Financial Policy

Thank you for choosing Aspen Endodontics for your endodontic needs. Our primary goal is to deliver the best endodontic care available in a comfortable and caring environment. We appreciate your trust and confidence in our office and look forward to making your experience as pleasurable as possible.

An important part of our service to our patients is to help make the financial aspect of your dental needs as easy and manageable as possible by offering several payment options. We accept Cash, Check, Visa, MasterCard, Discover, American Express and CareCredit. Payment is expected on the date of service.

If you have dental insurance, we will work with your insurance company to help you maximize your benefits. We are happy to submit the necessary paperwork for you to your insurance carrier for payment. It is important to understand that most dental plans will pay for only part of the cost of your treatment. This will be based on ***your*** individual policy and specific benefit package. Because each dental plan is unique and has its own fee schedule for various types of dental treatment, it is impossible to know exactly how your treatment will be covered until the claim is submitted and reviewed by your carrier. We will do everything we possibly can to contact your insurance company to verify your benefits and give you an estimate of how they will pay for your treatment and what your patient portion will be. Whether we obtain this information from your insurance company by telephone, the internet or through the mail, your insurance company does not guaranty coverage and payment for services rendered until the claim is actually submitted and reviewed. ***It is important to understand that your dental coverage is an agreement between you and your insurance company and that the information we provide you regarding your dental coverage is simply an estimate and is based on information we obtain from your insurance company.*** If, after receiving payment from your insurance, there is a difference in our estimate, we will refund any credit due or bill you for any balance remaining. If we have not received payment from your insurance company within 60 days of submitting your claim, you will be responsible for full payment of the account for services received. **We trust that you understand that we are providing services to you and that you, not your dental insurance, are ultimately responsible for payment of services you receive in our office, regardless of the estimated insurance information we provide you. We ask that you pay your *estimated* patient portion at the time of service.** If you have questions or concerns regarding your insurance benefits, we recommend that you refer to your policy and/or call your insurance company directly.

If you have any questions or unusual financial circumstances, please consult our financial coordinator prior to treatment. ***If you are unable to make your estimated payment on the date of service, we ask that you reschedule your appointment to a time that will be more convenient for you.***

The GentleWave Irrigation System and Waterlase/Epic Lasers are state-of-the-art technology that we use in our office and, depending on your specific treatment needs, may be used as part of your endodontic treatment. If the GentleWave or Laser systems are used for your treatment there will be an additional fee of $98.00 per tooth treated that is not covered by your dental insurance. This fee will be collected directly from you as part of your patient portion.

Our office reserves the right to charge the following fees: $35.00 Returned Check Fee; $65 Missed Appointment Fee (for broken appointments with less than 24 hours notice); $20.00 Late Fee (per month for outstanding account balances over 30 days); $40.00 Collection Fee (if your account becomes delinquent it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees and collection agency costs).

By signing below, I verify that I have read, understand and agree to this financial policy and accept financial responsibility for services received at Aspen Endodontics. I have also read and understand the Notice of Privacy Practices.

Signature _____ Date: _____