DESERT BLOOM DENTISTRY

Shawn B. Layton, DMD
Steven M. Cooper, DMD

928-428-1617
1475 S. 20th Avenue | Safford, AZ 85546

FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience, we accept cash, Visa, MasterCard, Discover, personal check money order, or registered check.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount is due at the time of treatment. Insurance is not a guarantee of payment; insurance companies will not pay for all of your costs. Your insurance policy is a contract between you and your insurer. Your insurance and payment are still your responsibility.

As a courtesy we will be glad to file your claim for you if you bring your dental insurance wallet card and all required employer information.

You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.

We request a 24 hour notice for missed or cancelled appointments. After two missed or cancelled appointments, patient may be asked to place a deposit to reserve future appointment times.

Returned Check Fee of $25.00 will be added to your account balance and is collectible.

Payment plans and financial arrangements can be entered into for comprehensive dental treatment prior to commencing treatment. Pre-payment and split payments are considered on a case-by-base basis.

Financial Responsibility: I am the person financially responsible for any debt in relation to service provided. I understand and agree to pay all insurance copays and amounts due for services not covered by insurance in advance at the time of service. (These services may include after hour visits, urgent office visits, extended office visits, procedures, and injections). I understand and agree that, except as otherwise provided by law, I am obligated to pay charges that are not paid by my insurance company within 90 days or immediately upon denial by my insurance company. Should this account be referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and costs and collection expenses. All delinquent accounts are eligible to bear interest.

I have read and understand this financial policy.

Printed Name _____ Signature _____

Date _____