ROBERT M. DELANEY, DDS
1121 S. HIGGINS AVENUE
MISSOULA, MT 59801
rmdddsxray@dr-delaney.com

Office Financial Policy and Release Of Records

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS AND ALL MAJOR CREDIT CARDS. WE ALSO OFFER **CARE CREDIT** WHICH IS AN EXTENDED PAYEMENT PLAN WITH PRIOR CREDIT APPROVAL.

SELF PAY ACCOUNT

Account balance is due in full at the time of service unless other payment arrangements have been made a 5% discount will be allowed on charges over $200.00 if paid at the time of service and paid by cash or check.

INSURANCE

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time of service is provided. The balance is your responsibility whether your insurance pays or not. We cannot bill insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy.

LEGAL

In the event an account is turned over for collection, the responsible person for the account agrees to pay the attorney's fees, court costs, any other 3rd party fees. Accounts over 30 days may be charged 10% per annum interest on the unpaid balance unless insurance is pending.

CANCELLATION POLICY

To make sure that every patient gets individual attention, we set aside dedicated time for each appointment. If you find it necessary to cancel an appointment, we require that you provide our office with 24 hour notice. If appropriate notice is not given, you may be charged a fee of $50.00 for each appointment that is missed or canceled without a 24 hour notice.

CUSTOM APPLIANCE CANCELLATION POLICY: All custom made appliances are non-refundable.

RELEASE OF RECORDS

I hereby authorize you to release my pictures, photographs, x-rays, films and other records in your possession that may include but are not limited to health history. Prescription list, special office needs requests, insurance information and in certain circumstances previous chart notes. Records may also be released to Dr. Delaney with the same items as written above.

I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED BY ME AT ANY TIME, PROVIDED THAT I DO SO IN WRITING, UP TO THE EXTENT THAT THE DISCLOSURE HAD NOT ALREADY BEEN MADE. THE REVOCATION IS EFFECTIVE FROM THE TIME IT IS COMMUNICATED TO THE HEALTH CARE PROVIDER. IT IS MY INTENT THAT INFORMATION FURNISHED IS PROHIBITED FOR ANY PURPOSE OTHER THAN THAT STATED ABOVE AND THAT THE RECIPIENT IS PROHIBITED FROM DISCLOSING THIS INFORMATION TO ANY OTHER PARTY TO WHOM DISCLOSURE IS NOT NECESSARY OR REQUIRED FOR THE PURPOSE STATED ABOVE.

I have read and agree to the above stated payment policies and release of records. I understand that I am financially responsible for all charges whether or not paid by insurance.

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Signature of Responsible Party **Date**

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Print Name