Nancy T. Simons, D.D.S., P.C.
4301 E. Amherst Ave. Denver, CO 80222
303-758-5858

FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care, to educate your family, and to create caring relationships in a compassionate, child friendly atmosphere. It is our policy to **make definite financial arrangements with you before any treatment starts.** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the **time services are rendered.** We accept **cash, checks and credit cards**: Visa, Mastercard and Discover. We also offer Healthcare Creditline Dental which gives you the ability to make afford able payments over an extended period of time.
2. **For new patient visits we require payment in full at the time of the appointment.**
3. As a courtesy we will file your insurance for you, and a refund will be made once coverage is verified.
4. If insurance benefits are assigned to the doctor you will be responsible for **paying your deductible and co-payments. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.**
5. Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.
6. **The office can not carry balances longer than 90 days.**
7. Delinquent accounts will be charged interest on unpaid balance
8. Should the account be turned over to a collection agency, you agree to pay all costs of collection including, but not limited to court costs, agency fees, and attorney fees.
9. There will be a $25.00 service charge for all returned checks.
10. **The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree may state.** Reimbursement must be made between the divorced parties. **We will not intervene.**

AUTHORIZATIONS

1. I authorize Dr. Nancy T. Simons to release any information concerning my case to my insurance company.
2. I have read and accept the above financial policy, understand it and agree to the terms set forth regarding my payment.

Patient Signature or Responsible Party if Minor	Date