

Ernest D. Bennett, D.D.S., P.C.
Family & Cosmetic Dentistry
1189 S. Perry Street #200 Castle Rock CO 80104
303-688-3008

Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your dental treatment being successful. 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 you read and sign prior to treatment.

Full payment of patient portion is due at the time of service.
We accept cash, checks, visa/mastercard or Carecredit.
Payment arrangements are available on higher balances.
All payment arrangements must be approved prior to treatment.

We will file your insurance for you as a courtesy. The balance is your responsibility whether your insurance pays or not. We must have a copy of your insurance card on file to ensure that it is submitted correctly or payment will be delayed and you will be responsible for payment. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract which limits our capability in dealing with them.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company arbitrary determination of usual and customary rates.

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rates of a normal office visit. Please help us serve you better by keeping scheduled appointments.

I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection (including but not limited to 30% of amount delinquent); any cost involved with litigation, and reasonable attorney fees. I hereby authorize the health care provider to release all information necessary to secure the payment benefits. I agree that a photocopy of this agreement shall be valid as the original. Thank you for understanding our Financial Policy. Please let us know if you any questions or concerns. I have read the Financial Policy. I understand the Financial Policy.

X _____
Signature of Patient or Responsible Party Date