LEGACY
DENTAL
Post Falls

- Patient Financial Policy -

801 East Medical Court
Post Falls, ID 83854
Phone: 208.773.1559 Fax: 208.773.9959

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope, that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable, we are pleased to offer you the following payment options. *Please select one:*

1. Cash or Check
2. Visa, MasterCard or Discover
3. Care Credit

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office—this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received. One and a half percent (1.5%) per month interest, eighteen percent (18%) per year will be charged on accounts 30 days from the treatment date.

Please make your questions and concerns known to our Accounts Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

_____ _____

Signature (Responsible Party) Date

How did you hear about our office? _____

Patient Information:

Name_____Birthdate_____
Last First Middle

Address_____ Patient's SS # _____

City_____State_____Zip Code_____

Female___ Male___ Child___ Married___ Single___ Other_____

Home Phone _____ Cell Phone_____

Email_____

Employer_____ Work Phone_____

Emergency Contact _____Relationship To Patient_____ Phone _____

RESPONSIBLE PARTY:

Name of person responsible for the account and their relationship to the patient_____

Address _____Home Phone _____Cell Phone _____

City _____State _____Zip Code _____ Responsible Party SS # _____

Employer_____Occupation _____

Work Phone _____

City _____State _____Zip Code _____

INSURANCE INFORMATION:

- **Dental Insurance card is on file**
- **If no dental insurance card, please complete the following info:**

Insurance Company _____ Insurance Phone _____

Insurance Address _____

City _____State _____ Zip Code _____

Full Name of Subscriber _____ Relationship to Patient _____ Subscriber Phone _____

Subscriber Birthdate _____ Subscriber SS # _____ Group# _____

Name of the Employer of the Insured _____

Work Phone _____