MT. Baldy Dental Center

Financial & Cancellation Policy

FINANCIAL POLICY

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. If a procedure requires multiple appointments we require payment at the time of your first appointment.

Payment Options:

1. Cash
2. Check
3. Visa
4. Master Card
5. Discover
6. American Express
7. CareCredit
8. Health Savings Account

- We DO NOT accept Medicaid

Patients with IN NETWORK insurance: We are in network with **Delta Dental** of all states and **Blue Cross of Idaho** only. THE PATIENT is responsible for the estimated non-covered portion, procedures and/or deductibles at the time of the service. As a courtesy service we provide a complementary benefits check to confirm your insurance coverage prior to your appointment, we REQUIRE a copy of your insurance card (front and back) 48 hours prior to your appointment. We will also send pretreatment estimates to Delta Dental and Blue Cross of Idaho only. We do not do pretreatment estimates for secondary insurance of any kind. Please keep in mind that even with a pretreatment estimate it is NOT a guarantee of coverage.

Patients with OUT OF NETWORK insurance: As a courtesy we will bill most dental insurance plans; however, it is the patient's responsibility to be aware of any limitations, and benefits of *your* insurance policy. We do not do insurance verification or pretreatment estimates for out of network insurances of any kind. As of January 1, 2025 we will be collecting 50% of the cost of any restorative procedures at the time of service. If your insurance pays more than 50% we can send you a reimbursement for any over payment when requested

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CANCELLATION POLICY

Because instruments, chair, and personnel are reserved exclusively for your appointment, there is a $50.00 charge for changed, broken or no-show appointments without 24-hour notice for a hygiene service. If an appointment is changed, broken or no-show with a doctor without 24-hour notice there will be a $100 charge. This policy does apply to VA patients as well.

I, _____, agree to the cancellation & financial policies

_____ _____

Signature of Patient / Parent / Legal Guardian Date