Front Range Dental Sleep Medicine, PC

Dennis R. Bailey, DDS - Andrew T. Smith, DDS

Financial and Office Policy

Welcome to Front Range Dental Sleep Medicine. We are dedicated to provide you the best care possible. Following are our current office policies;

1. We will bill your insurance claims to your insurance carrier as a courtesy providing we have your current and complete insurance on file. If current and accurate information is not on file you will become responsible for the payment of services rendered.

2. We accept payment from insurance companies but you are personally responsible for any copayments, coinsurance and deductibles at the time of the visit. If copayments are not made at the time of the visit a $10 fee will be assessed to your account for which you will be personally responsible.

3. Should your insurance company require a referral it is your responsibility to obtain a referral from the primary care physician. This needs to be on file in our office prior to your appointment. If there is no referral on file you will become responsible for the payment at the time of the visit.

4. It is our responsibility to pre-authorize any treatment per our recommendations. As a courtesy we make every effort to check on insurance coverage and benefits. However, it is your responsibility to know your coverage and benefits and personally check on them. Your insurance policy is a contract between you and your insurance company.

5. Account balances are due within 30 days of billing. If you are unable to make payment in full, please contact our office to make payment arrangements.

6. A failed appointment without 24 hours notice will result in a $25 fee assessed to your account and will become your personal responsibility.

7. We make every effort to run on time and we appreciate you being on time for your appointment. If you are more than **10 minutes late** you may not be able to be seen. New patients please be **15 minutes early** to allow time to complete your paperwork.

Please sign below to confirm you have read and understand our financial policy.

Name _____ Date_____

Patient Signature

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