Summit View Dental
Jennifer Foster, D.D.S
www.summitviewdds.com.

Financial Policy

Thank you for choosing Summit View Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Cash, Check, Visa, Mastercard, Discover Card or Care Credit.

Summit View Dental requires payment at the beginning of your treatment. For larger, more comprehensive treatment plans, a 50% deposit is required to secure your initial treatment appointment. A fee of $50 is charged for patients who miss or cancel within less than 24 hours without notice. Summit View Dental charges $35 for returned checks.

For patients with dental insurance: we are happy to work with your carrier to maximize your benefit and we will directly bill them for reimbursement for your treatment. Patient are always responsible for 100% of fees not paid by insurance.

Assignment of Benefits: I hereby assign all dental benefits, to include major medical benefits to which I am entitled, and authorize and direct my insurance carrier(s) to issue payment check(s) directly to Summit View Dental for dental services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

If you have any questions, please do not hesitate to ask. We are here to help you receive the dentistry you want or need.

We provide an estimate based on limited information obtained from your insurance company. ***We expect you to pay your estimated share of the total fee at your visit.*** Dental insurance rarely pays all of the charges, and you are always responsible for the total amount.

PAST DUE BALANCE – INTEREST RATE

We reserve the right to charge 1.5% interest on past due balances beginning 30 days past the due date.

AUTHORIZATION AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Patient/Guardian Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____