GLACIER VALLEY
ENDODONTICS

Financial Policy

Payment is due in full at time of service for all procedures. We gladly accept Visa, Mastercard, American Express, Discover, debit cards, checks and cash. For patients without dental insurance a 5% discount is given for cash. Six month, no interest payment plans are available through Care Credit, and Chase Healthcare Financial and are subject to approval from these companies. Applications for these plans can be accessed through our website or by phone: Care Credit - 1 (800) 365-8295 and Chase financial - 1 (800) 510-5638.

If you have dental insurance, 50% of the total is due at the time treatment is rendered, with the exception of Blue Cross/Blue Shield. Payment is due in full at the time of service for patients with Blue Cross/Blue Shield, as they pay the patient back directly. As a courtesy to you, we will gladly process and submit your insurance claim. ***However, if this claim is not paid by your insurance company within 30 days, the balance is your responsibility and due immediately.*** If your account has not been paid in full within 45 days after the date of service, a late charge will be assessed. If there is a balance to you on your account after insurance has paid your claim, a check for the difference will be sent to you. Claims are filed on behalf of our patients for dental services performed in the office to the primary insurance company. Secondary insurance is the patient's responsibility. To assist in filing your secondary claim, we will give you a complete statement of services from our office. Dental insurance benefits belong to you, and it is up to you to ensure that you are receiving appropriate reimbursement under the terms of your plan. There is no guarantee of benefits from the insurance company until a claim is received and processed by the insurance company. Therefore, benefits quoted to you are only an estimate provided by the insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY ME DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

Patient's Name (Printed) _____

Signature of Patient / Guardian _____

Date _____