BOISE INTEGRATIVE DENTISTRY EST. 1977

FINANCIAL AGREEMENT FOR DRS. BRUCE, RIRIE, & POTHIER

This agreement is to inform you of your financial obligations to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employers, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full. As a courtesy to you we will help you process all your insurance claims. In order for our practice to file your insurance claim, you must bring your insurance card at each appointment. You may direct your insurance company to pay your benefits directly to our office by signing below.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time of treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express and Discover. Third party, extended payment financing, through Care Credit is available upon request and approval.

Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

MISSED APPOINTMENT POLICY

If you cannot keep an appointment, we require a minimum of 24 hours notice. This courtesy on your part allows us to give the appointment to another patient needing to be seen.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

_____	_____	_____
Print Name of Patient or Responsible Party	Signature of Patient or Responsible Party	Date

I authorize my insurance company to pay my dental benefits directly to Bruce DMD and Ririe DDS:

_____	_____	_____
Print Name of Patient or Responsible Party	Signature of Patient or Responsible Party	Date