Dr. Heidi C. Browne, DDS Dr. Bradley S. Grammens, DDS
2744 Colonial Drive
Helena, MT 59601
406-442-0282
info@mtrootsdental.com

Financial Policy

As validated by my signature on the bottom of this form, I understand and agree that:

All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.

Should a balance accrue on my account, a statement will be sent and payment is to be made in full, by the date on the statement. If payment is not paid within 30 days, interest may be applied to the entire account balance. A revised statement with the a new account balance, payable immediately, will be sent.

A returned check fee of $35 will be applied to your account and must be paid by you for each check payment returned to us by your bank.

Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by Montana Roots Dental Care, not an obligation. Montana Roots Dental Care will bill primary and secondary insurances on the patient's behalf. Any third (tertiary) insurance is NOT able to be billed by Montana Roots Dental Care. Ultimately, I I am responsible for any treatment cost that is unpaid by the insurance provider. I understand that I must provide Montana Roots Dental Care with the correct and current insurance information.

If there is dental insurance, I understand that Montana Roots Dental Care has established the patient balance based on the insurance information that I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

Pre-treatment estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been included in the total.

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Financial Policy Continued

Estimates do not take into consideration any payment that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.

A submission to my insurance provider may be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the insurance claim. Pre-authorizations from my insurance provider(s) ARE NOT a guarantee of payment. Should they deny payment, I understand that I am responsible for the full amount not covered by my insurance provider(s).

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. Montana Roots Dental Care will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified to accomplish the best result possible.

Montana Roots Dental Care will make every effort to accommodate my scheduling needs.

The parent or guardian who consents to treatment for a minor is responsible for all costs incurred with treatment after insurance claims have been processed.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

Patient Name (Printed):_____

Patient (or Guardian) Signature: _____

Date:_____