Signature Dental

Paul A. Dona, DDS
1201 S. Elk Street
Casper, WY 82601
Phone: (307)234-3890 Fax: (307)472-5583

FINANCIAL POLICY

Our top priority is to provide you with the best dental health care possible, regardless of your insurance situation. With so many different dental plans available to our patients, we cannot be responsible for knowing the details of the coverage for each of them.

It is the policy of our office that payment for dental services is due at the time services are provided. When appropriate, and in accordance with your insurance plan, we will request co-payments, deductibles and/or co-insurance amounts at the time of service. We will submit all claims to your insurance company as a courtesy. Our submission does not guarantee payment from your insurance company. You are responsible for charges denied by your insurance company.

We offer a variety of convenient payment options. We accept Cash, Checks, Visa, MasterCard, Discover, American Express and Care Credit. If a credit card payment is made by phone, your signature below will grant our office permission to process the payment. Charges unpaid after 120 days are delinquent and may be placed with an outside agency unless you have a signed payment agreement with us. Should my account be referred to an attorney or collection service for non-payment, I agree to pay reasonable attorney fees, costs and collection expenses. Additionally, any returned checks will be subject to a fee of $35.00.

We kindly request a minimum of 24 hours notice for any appointment changes including cancelling or rescheduling of an appointment. If you cancel or no-show an existing appointment without 24 hours notice you will be charged a $50 fee and it must be paid prior to being seen at your next appointment.

I have read and understand the above Financial Policy for Paul A Dona D.D.S. and I agree to the terms and conditions specified.

_____ _____

Patient Name (printed) Date

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Patient Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been given the right to review the Notice of Privacy Practices of Paul A. Dona D.D.S. (HIPAA) Please notify the front office if you would like a copy of this document.
I understand that my Protected Health Information (PHI) may be used and disclosed for the purposes of treatment, payment and healthcare operation of the practice.

_____ _____

Patient Name (printed) Date

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Patient Signature