RED ROCKS
ENDODONTICS LLC

PRACTICE LIMITED TO ENDODONTICS
2535 S. Lewis Way • Unit 105 • Lakewood, CO 80227
(303) 458-0444
Fax: (303) 232-6154

Thank you for choosing us for your endodontic care. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read prior to any treatment.

All patients must complete our Registration and Medical/Dental History form before seeing the doctor.
FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

REGARDING INSURANCE
We do require that you pay your portion (Co-Payment or deductible) at the time of service. This may be 20% to 50% of the total bill. **The balance is your responsibility whether or not your insurance company pays.** We cannot bill your insurance company unless you give us your insurance information and allow us to make a copy of your insurance card. **Your insurance policy is a contract between you and your insurance company.** We are not a party to that contract. Please read and know your own insurance policy. If your insurance company has not paid within 90 days, you will be responsible for the balance in full. Please be aware that you will be responsible for any treatment received not covered by your policy.

WE ACCEPT ALL INSURANCE PLANS BUT WE ARE ONLY PARTICIPATING PROVIDERS with **DELTA DENTAL, CIGNA-radius, Aetna PPO, Connection Dental, Assurant DHA, and DenteMax.** In the event your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge fee's that are customary for endodontists in our area. You are responsible for payment of any insurance company's arbitrary determination of usual and customary rates.

PATIENTS WITHOUT INSURANCE
Patients without dental insurance are responsible for payment in full when treatment is received unless financial arrangements have been made prior to appointment.

FINANCIAL ARRANGEMENTS
In the event a short-term financial arrangement is necessary, payment options will be discussed on an individual basis with the office manager.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Treatment will not be rendered without the signature of the patient on our Financial Policy.

I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

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PATIENT SIGNATURE (PARENT OR LEGAL GUARDIAN) DATE