PRILL DENTAL

Richard D. Prill DDS PLLC
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BILLING AND PAYMENT POLICY

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

1) A monthly statement will be send to me for any balance due that will detail all charges, payments and credits entered on my account during the month preceding the closing date of the statement.

2) This office will submit insurance claims and will allow sixty (60) days for those claims to be paid. Balances that remain at the end of the 60-day period require monthly payments even if insurance claims are pending. Payment of the estimated percentage not covered by insurance, including deductible and co-pays, are due at the time of service. Overpayments will be reimbursed within thirty days.

3) Patients without insurance coverage should pay in full at the time of service unless financial arrangements are made.

4) A one and a half percent (1 1/2%) finance charger per month with be assessed against the unpaid balance of all accounts that are 90 days old or older unless the account is paid in full in four months. Equal to 15% a year.

5) In accordance with the Federal Truth in Lending Act, a Truth in Lending Statement will be forwarded to me should my payments exceed four months. The Truth in Lending Statement reflects the total balance due, down payment, interest charges, payment agreement and the first payment date. A signed copy should be returned to this office within ten (10) days.

6) A $40.00 charge will be assessed for each 30 minutes of missed appointment if not excused within 24 hours of that appointment.

7) If covered by Medicaid, a $3.00 co-payment is required by law before service can be rendered.

8) Medicare will not pay for dental work in the state of Montana.

9) Due to lab cost, dentures and crowns must be paid for in full before time of delivery or cementation.

10) Should my account become delinquent, I agree to pay reasonable collection costs, attorney fees and court costs as permitted by law if such are incurred by Prill Dental.

11) I have retained a copy of this agreement.

I have dental insurance [ ] YES [ ] NO

Date: ____________________
Name of insurance company ____

Patient name: ____

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