



DENTAL ARTS

Dana M. Boyd-Page, DDS

Page Dental Arts, Professional LLC

8204 S. Kipling Parkway, Suite 160

Littleton, Colorado 80127

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## Appointment Policies

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### **Cancellation Policy**

Here at Page Dental Arts, your appointment time is reserved especially for you. Missed appointments and short notice cancellations are an attributing factor to the ever-rising costs of health care. We understand that our patients have busy schedules and that emergencies do arise, however, we ask that you notify us 48 hours in advance to cancel or reschedule your appointment. We DO NOT charge our patients for missed appointments or short notice cancellations, however, if a patient shows repeated disregard for this policy, they will be asked to seek dental care elsewhere.

### **Parent/Guardian Policies**

All new patient paperwork and/or consent forms for treatment must be filled out and signed by a parent/guardian for all patients under the age of 18 prior to treatment.

We ask that a parent/guardian remain on the premises during treatment of their child in case of an emergency or in order to review treatment changes. If you are not present during treatment, you understand the doctor will make any necessary decisions on your behalf based on her professional judgment. If you are not present to review exam findings or any treatment complications with the doctor, a consultation with the doctor will occur at her earliest convenience.

We prefer that the only persons present inside the treatment room are clinical staff and the patient being treated. This is to ensure everyone's safety. However, upon request, we will allow a parent/guardian in the treatment room during treatment for children under the age of 18. Due to space constraints, only one parent/guardian will be allowed in the treatment room. If the parent/guardian wishes to be in the room, we ask that they refrain from interrupting or distracting the doctor or other clinical staff. We also ask that you have any questions addressed prior to treatment, not during treatment.

### **Emergency Appointments**

We hope that you never experience a dental emergency. However, if you find yourself with a dental emergency, we request that you call our office immediately. Our goal is to work you into our schedule the same day to determine any necessary treatment and alleviate any pain. Please realize in emergency situations the most important thing is getting you evaluated as soon as possible. Therefore, convenient appointment times (i.e. early morning or late evening) may not be available, however, we are more than happy to provide work or school excuse forms.

### **After Regular Business Hour Emergencies**

We understand that dental emergencies don't always happen in the middle of the week. If you find yourself with a dental emergency after hours or on the weekend that requires immediate professional attention, we ask that you call our office phone number and follow the prompts to be transferred to the doctor's mobile phone. The doctor will then take or return your call and instruct you on your particular situation. If an after hours office *visit* is required, it may be subject to an after hours visit fee of \$90. Depending on your insurance plan this fee may or may not be covered.

Please **DO NOT** leave an urgent message on the regular office voicemail, as it will not be checked until the next business day!!

\*\*If you feel your emergency is life threatening, you should dial 911 for immediate assistance.\*\*

I understand the above policies and agree to follow them.

Print Patient Name: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Financial Policies

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At Page Dental Arts, we believe in the importance of quality dental care, and we strive to provide the best dental treatment possible. We also understand the financial limitations that influence your choice of care. We would like to take the time to make you aware of our financial policies and financing options.

**PAYMENT:** Payment is due in full at the time of service, unless other financing arrangements with Care Credit are made in advance. We accept multiple payment forms such as cash, check, debit card, credit card or Care Credit. A photo ID must be presented when using a credit card, and only the person whose name appears on the credit card is allowed to sign for payment. All returned checks are subject to a \$20 fee, and we may electronically debit or draft your account for this charge.

**DENTAL INSURANCE:** We accept most major dental insurance plans. We are in network with the following EPO or PPO plans: Aetna, Assurant/DHA (through Aetna), Ascent, Cigna, Dental Benefit Providers (DBP), Delta Dental Premiere and Preferred, Guardian, Metlife, and United Health Care. We do not accept any DMO/HMO plans or Medicare/Medicaid. We are happy to research your insurance to determine your benefits at our office. However, the best way to ensure you will have benefits at our office is for you to call and check with your insurance company to see if there are any restrictions on where or who you can see for your dental treatment.

As a courtesy to all of our patients, we are happy to accept payment from your insurance company and file your dental claims for you at no charge. However, your "co-pay" or any "estimated patient portion" is due in full at the time of service. In order to file your insurance, we require that you provide us with up-to-date information about yourself, your insurance company, and the subscriber. This means you will need to provide us with the subscriber's ID number. For most plans, this is the social security number of the subscriber. Failure or refusal to provide us with necessary information will result in you filing your own dental claims and paying for your services in full.

Understanding your insurance benefits can be a difficult thing. We will make every effort to determine your benefits and estimate what your insurance will cover, and we will notify you prior to treatment of this estimate. However, if your insurance denies a claim or only pays a portion of what was expected, you are responsible for the difference. We will also do our best to help educate you regarding your dental insurance plan, however, it is your responsibility to understand your own plan and ask questions if you do not understand. It is also your responsibility to keep track of your plan's maximum benefit allowance.

**TREATMENT FINANCING:** Our office participates in special health care financing through Care Credit. Care Credit can allow you to pay a monthly amount over time with a low or even 0% interest rate. If you are interested in setting up a payment plan through Care Credit, please be sure to let our staff know prior to treatment.

**BILLING, INTEREST AND COLLECTIONS:** Payment or your "co-pay" is due at the time of service. Failure to pay at the time of service will result in a 10% billing fee (\$10 minimum). If your insurance denies a claim or only pays a portion of what was estimated, you will be billed for the remaining balance. Statements are usually processed and mailed at the end of the month for remainder balances greater than \$5. Payment is due upon receipt of the statement. There is no billing charge for this process. A 5% interest charge may be applied to balances that are not paid within 90 days of an initial statement being released. If payment is still not received within 120 days from the initial statement date, your account will be sent to a collection agency. The balance of the account, as well as any collection agency fee, is your responsibility.

**OVERPAYMENTS:** If an overpayment occurs and leaves a credit balance on your account greater than \$5, a check will be mailed at the end of the quarter refunding this credit as long as there is no pending treatment. If there is pending treatment, you will be notified by phone of the credit and to schedule your treatment. You may request a refund check at this time if you do not wish to schedule your treatment.

I have read and understand the above financial policies, and I agree to follow them:

Print Patient Name: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_