Financial Policies

The Montana Center for Laser Dentistry accepts several forms of payment for dental treatment provided at this office

Cash, debit card, personal check, business check (by an authorized person)
***Credit Cards*;** MasterCard, Visa, American Express, Care Credit

Dental Insurance: Understanding your insurance coverage can be quite a challenge. Our goal is to assist you in maximizing your benefits We care for patients from many different employers. Each company pays an insurance premium for specific coverage which fits the employer's budget. Each plan is different in it's covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:
1) Filing your insurance electronically (when available) within 24 hours of service and requesting payment be sent directly to us.
2) Following American Dental Association guidelines for coding procedures and filing insurance.
Our expectations of you as the owner of the policy:
1) Payment of fees not covered by your insurance plan at time of treatment.
2) Please understand that the insurance policy belongs to **you** and we have no leverage to obtain payment from your the insurance carrier. The insurance contract is between yourself, the carrier and possibly your employer.
3) Realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called UCR) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, not our fees or recommended treatment.
4) You will have to take responsibility for any fees your insurance has not covered after 60 days. The balance on your account will be charged to your credit card. If any amount is left outstanding, subsequent statements will be charged a $5.00 late fee and interest will accrue at 1.5% per month of the outstanding balance. Any expenses incurred in collecting a past due account will be added to the balance. Expenses can include but are not limited to attorney fees, collection agency fees up to 45%.
I hereby authorize Dr. Colonna and any Associates of The Montana Center for Laser Dentistry to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Colonna, I understand I am responsible for any unpaid balances.
I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs will be added to the balance of my account.
I authorize Dr. Colonna to keep my signature on file AND to charge my credit card with balance of charges not paid by insurance within 61 days after treatment has been rendered not to exceed $_____ for all visits this year.

I understand that treatment can not be completed until it is paid for (i.e. crowns will not be cemented, dentures will not be placed).
I understand that if I do not have a credit card on file, it will be necessary for me to have an open Care Credit account (90 days interest free) on which The Montana Center for Laser Dentistry can charge any balances not paid with 61 days.

_____Date _____
Responsible Party Signature

What family members are covered by this agreement?_____

Credit Card on file * required*
_____—_____—_____—_____

Expiration date_____
Please circle : MC, Visa, Amex ,Discover or Care Credit