DENMARK DENTAL
1519 Central Parkway
Suite 240
Eagan, MN 55123
Office: 651-452-4455
Fax: 651-452-1270

OUR OFFICE GUIDELINES

Thank you for choosing Denmark Dental. We consider it the right of every patient to receive the best dental care we can provide and have all treatment options and costs disclosed and thoroughly explained. We are happy and willing to discuss our procedures and fees as well as answer your questions.

A WORD ABOUT YOUR DENTAL BENEFITS

Our office accepts the assignment of benefits from many (but not all) standard plans and is a participating Delta Dental provider for *most* of the plans offered. Because we cannot be familiar with each patient's prior utilization or level of benefits, we ask for the patient's portion of payment at the time of service. We will submit claims for you but cannot guarantee payment by your benefits plan. We ask our patients to participate in understanding your plan's dollar limits, deductibles and services or provider exclusions outlined in your benefits program. Patients (responsible parties) are ultimately responsible for your account balances regardless of coverage. Please ask our Care Team if you are unsure of your benefits; we are happy to help.

FINANCIAL OPTIONS

- **Payment in Full at Time of Service**
  - **a.** A 5% Courtesy Savings with payment by check or cash
  - **b.** A 7% Senior (65 and older) Courtesy Savings with payment by check or cash (These options apply only to patients with no benefit plans)
- **WE ACCEPT Visa, MasterCard, Discover and American Express** for your patient balance, as well as check and cash payments
- **Financing** Through Our Outside Program with CareCredit®; Ask Us How
- **Patients with dental plans that assign their benefits to our office will be asked to pay their estimated patient portion at the time of service. If your plan pays more on your services than estimated and results in a credit balance you will be reimbursed. If a patient balance remains after your dental benefits makes their payment, *we will send you a final statement and we require payment in full within 30 days of the statement date*.** **PLEASE INITIAL:_____**
- **We Ask** that you give our office at least a *2 business day notice and we require a minimum of 24 hours* if you find it necessary to change an appointment for yourself or a family member. It helps us to provide openings for other patients waiting for treatment. *Patients who miss or do not provide us advanced notice may be charged for the missed appointment time or we may choose to discontinue our services.*
- **Finance Charges** of 1.5% will be computed on any unpaid balance of 90 days or over

AUTHORIZATION OF ASSIGNMENT OF DENTAL BENEFITS

I/We hereby authorize and direct payment of dental benefits otherwise payable to me, directly to Denmark Dental

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Signature of Patient – Parent – Legal Guardian (Financially Responsible Party) **Date**

I have read, understand and agree to the office guidelines and financial terms of Denmark Dental

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Signature of Patient – Parent – Legal Guardian (Financially Responsible Party) **Date**