FINANCIAL POLICY

Dr. Le is participating in the following dental insurance plan networks:

Aetna Dental PPO
Ameritas Dental PPO
Cigna Dental PPO
Delta Dental PPO & Premier
Guardian Dental PPO
Logistics Health Inc.
Metlife Dental
Principal Dental PPO

(We do not participate with Medicare or Medicaid)

If your insurance plan is one of the above listed plans, you will be responsible for your co-payment or estimated patient portion on the day services are rendered. We will process your insurance claim for you if complete current and accurate information is provided. After we receive payment from insurance you will be billed for any remaining balance, which is due within 30 days of the statement date.

If your insurance plan is a **non-participating plan,** or you do not have insurance, payment for services are due in full at the time services are rendered. We will be happy to file your insurance claim for you and benefits may be sent directly to you. Any amounts paid to Dr. Le by the non-participating plan will then be refunded to you at the end of that current month in which it was paid. Disputes of coverage, benefits, deductibles, etc. are strictly between you and your insurance company.

We gladly accept cash and checks with no additional fee. Visa, MasterCard, American Express and Discover require a **3% transaction fee** for payment of surgery**.** We also offer financing plans through Care Credit or Key Bank. Balances older than 30 days will be charged interest of 1½% per month. There will be a $50 fee for appointments cancelled without 24-hour advance notice. Returned checks will also be subject to additional fees. Delinquent accounts will be subject to collection services. Customer agrees to pay all court costs and reasonable attorney fees for collection of accounts ninety (90) days or more past due.

We must emphasize that as a dental/healthcare provider our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.

There is a $5 service charge if you request a copy of your records.

____________________ ______________________________

Date Signature

Thao T. Le, D.D.S., M.D.
1840 Folsom Street Suite #304 │ Boulder, CO 80302
Phone (303) 449-9840 │ Fax (303) 545-9712
www.bouldervalleyoms.com

Please provide the following current and accurate information in order for us to bill your insurance company.

BILLING INFORMATION:

Person financially responsible for charges____

Relationship to Patient ____

Address___________________________ City____________________State_____Zip___________

Phone number _____________________________________ (work)_________________________

INSURANCE INFORMATION:

Dental Insurance Company____

Policy Holder's Name_________________________________ Date of Birth__________________

Policy Holder's Address____

Member/Subscriber ID#______________________________ Group #________________________

Medical Insurance Company____

Policy Holder's Name__________________________________ Date of Birth_________________

Member/Subscriber ID#_______________________________ Group #_______________________

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to my billing or insurance information.

__________________________ ____

Date Patient or Parent/Guardian Signature

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