



BOULDER VALLEY
ORAL & MAXILLOFACIAL SURGERY

FINANCIAL POLICY

We participate in the following dental insurance plan networks:

| | |
|-------------------------------|-----------------------|
| Aetna Dental PPO | Guardian Dental PPO |
| Ameritas Dental PPO | Logistics Health Inc. |
| Anthem Blue Cross Blue Shield | Metlife Dental |
| Cigna Dental PPO | Principal Dental PPO |
| Delta Dental PPO & Premier | |

(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 within 90 days from the date 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